



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

December 13, 2005

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #82

The following acronyms are used in this transmittal:

- ABD – Aged, Blind or Disabled
- AC – Aid Category
- AAL – Alzheimer's Assisted Living Waiver
- CBC – Community-based Care
- CDPAS – Consumer-directed Personal Assistant Services Waiver
- COLA – Cost of Living Adjustment
- CPU – Central Processing Unit
- CNNMP – Categorically Needy Non-money Payment
- DD – Developmental Disabilities Support Waiver
- DRS – Department of Rehabilitative Services
- DS – Day Support Waiver
- DSS – Department of Social Services
- EDCD – Elderly or Disabled with Consumer Direction Waiver
- ESHI – Employer Sponsored Health Insurance
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- FPS – Family Planning Services
- HIPPP – Health Insurance Premium Payment Program
- ICAMA - Interstate Compact on Adoption and Medical Assistance
- ICF-MR – Intermediate Care Facility for the Mentally Retarded
- IMD – Institution for Mental Diseases
- LDSS – Local Department of Social Services
- LTC – Long-term Care
- MMIS – Medicaid Management Information System
- MN – Medically Needy
- PD – Program Designation
- QI – Qualified Individuals
- QMB – Qualified Medicare Beneficiary
- SS – Social Security
- SSA – Social Security Administration
- SSI – Supplemental Security Income
- SSN – Social Security Number
- VA – Veterans Administration

The attached Medicaid Transmittal #82 contains new, updated, revised, and clarified policy as outlined below.

New policy

This transmittal contains a new eligibility requirement effective January 1, 2006. The new eligibility requirement states that each individual age 19 or over who requests medical assistance must verify his/her citizenship or legal presence in the United States. This policy is effective for all applications and renewals dated on or after January 1, 2006. This policy does not apply to FAMIS, FAMIS MOMS, or those individuals applying for Medicaid payment of emergency services only. This transmittal also contains new policy about the two new Medicaid waivers, the Alzheimer's Assisted Living Waiver and the Day Support Waiver, which were introduced in Broadcasts #3255 and #3348, and new policy regarding the treatment of prescription drug copays for CBC patients who have Medicare.

Revisions to existing policy

The ABD income policy on excluding retroactive SSI and SS payments as a resource was changed from 6 months to 9 months following the month of receipt effective with Broadcast #3456, dated November 1, 2005. Other revisions to policy in this transmittal include: deleting the Local Choice eligibility requirement for FAMIS, and changing the name of the FAMIS ESHI component to "FAMIS Select."

Updates to policy

This transmittal contains the January 2006 SSA COLA, the increases in the Medicare premiums, the increased income limits and deeming allocations based on the increased SSI payment levels, the increased ABD student child earned income exclusion, and the increased LTC spousal resource and maintenance standards. These new amounts must be used for all Medicaid eligibility determinations made on or after January 1, 2006. The January 2006 patient pay for institutionalized recipients who receive an increase in benefits, and/or who have community spouses, must be adjusted in December to reflect the new standards and the increased income amounts. The institutionalized recipient or his authorized representative must be notified in advance of the change in the patient pay that is effective on January 1.

Other updates to policy include updating the Health Insurance for Children and Pregnant Women application form and updating references to issuance of Medicaid ID cards.

Clarifications of policy

Clarifications to policy in this transmittal include: required verifications; Virginia residency of a U.S. citizen child born in the U.S. to alien parent(s); the need for a written eligibility evaluation form; where to send the DMAS-122 forms for waiver services recipients; and that Medicare, Medicaid and State/Local Hospitalization are not "health benefit plans" for FAMIS and FAMIS MOMS eligibility purposes.

Effective date

The policy clarifications, revisions and updates contained in this transmittal are effective for all eligibility determinations completed on or after January 1, 2006, except for the new waivers which

were implemented in the summer of 2005 and the change in the ABD exclusion of retroactive SSI and SS payments to 9 months that was effective November 1, 2005.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0120 Table of Contents pages 5-8 page 13 Appendix 6, pages 1-6 Appendix 6a	Subchapter M0120 Table of Contents pages 5-8a page 13 Appendix 6, pages 1-6	Updated the Table of Contents. Page 5 is reprinted. On pages 6, 7 and 8, clarified the application policy for Foster Care children, and for Adoption Assistance and Non-IV-E Special Medical Needs Children. On page 8a, deleted the reference to Appendix 6a. On page 13, added the application policy for QI, and designated the "Application Date" section as item C. The current Health Insurance for Children and Pregnant Women application form replaces the old form in Appendix 6. Deleted Appendix 6a.
Subchapter M0130 Table of Contents pages 3-8	Subchapter M0130 Table of Contents pages 3-8 Appendix 2	Updated the Table of Contents. Page 3 is reprinted. On page 4, clarified the verification policy, and moved the dependent child information to the list of requirements that do not require verification. On page 5, clarified the exceptions to the SSN policy. On pages 5 and 6, added the legal presence eligibility requirements effective January 1, 2006. On page 6a, clarified the HIPP policy, asset transfer verification policy, and clarified the eligibility determination evaluation to require a written eligibility evaluation. On page 7, deleted references to "VaMMIS;" the Medicaid computer system is referred to as "MMIS." Page 8 is reprinted. Added Appendix 2 containing the "Affidavit of United States Citizenship or Legal Presence in the United States."

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0210 Table of Contents pages 1-3	Subchapter M0210 Table of Contents pages 1-4	Updated the Table of Contents. Referenced the legal presence policy on page 1. Updated the example on pages 1 and 2. On pages 3 and 4, added the legal presence policy, changed the title of section M0210.200 and deleted the references to the old covered group classifications.
Subchapter M0220 pages 1, 2	Subchapter M0220 pages 1, 2	On page 1, deleted references to the “Declaration of Citizenship” form. On page 2, clarified policy by adding a note that a child born in the U.S. to non-citizen parents here as employees of another country’s government may not be a U.S. citizen, and to check the Virginia residency policy for children born in the U.S. to non-citizen parents.
Subchapter M0230 pages 3, 4	Subchapter M0230 pages 3, 4	On page 3, clarified that a child living with alien parents who are in the U.S. temporarily meets the Virginia residency requirements if the parent(s) declare the intent to remain in Virginia permanently or for an indefinite period. Page 4 is a runover page.
Subchapter M0240 pages 1, 2	Subchapter M0240 pages 1, 2	On page 1, added policy stating that the submission of the legal presence affidavit without proof of an application for an SSN does not meet the SSN requirement for Medicaid eligibility. Page 2 is a runover page.
Subchapter M0250 pages 5-8	Subchapter M0250 pages 5-8	Pages 5 and 8 are reprinted. On page 6, added the word “applicants” to item C to clarify that the policy applies to both applicants and recipients. On page 7, clarified the 501 form requirement.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0290 pages 3, 4	Subchapter M0290 pages 3, 4	On page 3, clarified the HIPP Application Process. Page 4 is a runover page.
Subchapter M0310 pages 35, 36	Subchapter M0310 pages 35, 36	Page 35 is a runover page. On page 36, clarified the verification requirements for a pregnant woman.
Subchapter M0320 pages 11, 12 pages 41, 42 pages 42c, 42d pages 50a, 50b	Subchapter M0320 pages 11, 12 pages 41, 42 pages 42c, 42d pages 50a, 50b	Page 11 is reprinted. On page 12, added the COLA and Medicare premiums for 2006. On pages 41 and 42c, replaced references to “PD” with “aid category” and “AC,” and deleted references to eligibility types. On pages 42 and 42c, clarified the January 1 application date requirement for QIs. Page 42d is reprinted. On page 50a, replaced reference to the special review code for an FPS enrollee with instructions to enter the actual date of delivery in the “Expected Delivery Date” field in the MMIS. Page 50b is reprinted.
Subchapter M0530 page 49 (Appendix 1)	Subchapter M0530 page 49 (Appendix 1)	On page 49, updated the deeming allocations.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	On page 1, replaced references to “classification” with “covered group”; updated the income limits for CNNMP protected covered groups. On page 2, updated the 300% SSI income limit.
Subchapter M0820 pages 29-32	Subchapter M0820 pages 29-32	Page 29 is a runover page. On pages 30 and 31, added the ABD student child earned income allowances for 2006. Page 32 is reprinted.
Subchapter M0830 pages 53-56	Subchapter M0830 pages 53-56	On page 53, clarified policy for support received for an adult child. Page 54 is a runover page. On page 55, deleted the text in section S0830.425 because the policy

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
		for child support is covered in section S0830.420; reserved the section title. Page 56 is left blank.
Subchapter S1130 pages 61, 62	Subchapter S1130 pages 61, 62	Page 61 is reprinted. On page 62, revised policy on excluding retroactive SSI and SS benefits.
Subchapter S1140 pages 25, 26	Subchapter S1140 pages 25, 26	Page 25 is reprinted. On page 26, clarified operating policy for annuities.
Subchapter M1410 pages 7, 8 pages 17-20	Subchapter M1410 pages 7-8a pages 17-20	On pages 7 and 8, added the DS and AAL waivers. On page 8a, references to “DMHMRSAS” replace “MHMR.” Added AAL Waiver information on page 17, and the DS waiver on page 19. Pages 18 and 20 are reprinted.
Subchapter M1420 Table of Contents pages 3-5 Appendix 4	Subchapter M1420 Table of Contents pages 3-5 Appendix 4	Updated the Table of Contents. Added the DS Waiver to pages 3, 4 and 5. Added the AAL Waiver policy to page 3. Added Appendix 4 containing the new “DS Waiver Level of Care Eligibility Form.”
Subchapter M1440 Table of Contents pages 15-18b pages 21-22	Subchapter M1440 Table of Contents pages 15-18b pages 21-23	Updated the Table of Contents. Page 15 is reprinted. On page 16, added the DS Waiver policy. Added the AAL Waiver policy to page 17. Page 18 is reprinted. On page 18a, updated the list of waiver services. Page 18b is reprinted. On page 21, added the DS Waiver to Day Support Services. On pages 22 and 23, added the description of prevocational services.
Subchapter M1460 pages 31, 32 pages 35, 36	Subchapter M1460 pages 31, 32 pages 35, 36	On pages 31 and 32, clarified the notes regarding VA payments. On page 35, added the ABD student child earned income allowances for 2006. Page 36 is reprinted.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
<p>Subchapter M1470</p> <p>pages 1, 2</p> <p>pages 21, 22</p> <p>pages 27, 28</p> <p>pages 45, 46</p> <p>pages 49-52</p> <p>pages 63, 64</p>	<p>Subchapter M1470</p> <p>pages 1, 2</p> <p>pages 21, 22</p> <p>pages 27, 28</p> <p>pages 45, 46</p> <p>pages 49-52</p> <p>pages 63, 64</p>	<p>Page 1 is reprinted. On page 2, clarified the note regarding VA payments. On pages 21 and 22, added the DS Waiver. Page 27 is reprinted. On page 28, added Medicare prescription drug copays to the list of non-covered medical expenses for CBC patients who have Medicare. On page 45, deleted “Type 4” from the example. On page 46, clarified item 2. Updated the example on page 49. On pages 50 and 51, added the DS Waiver to the policy about where to send the DMAS-122 form. Page 52 is a runover page. Clarified the reduction of resources procedure and example on pages 63 and 64.</p>
<p>Subchapter M1480</p> <p>pages 9, 10</p> <p>pages 13, 14</p> <p>pages 17, 18</p> <p>pages 65, 66</p> <p>pages 69-72</p> <p>pages 77-80</p> <p>pages 93, 94</p>	<p>Subchapter M1480</p> <p>pages 9, 10</p> <p>pages 13, 14</p> <p>pages 17, 18</p> <p>pages 65, 66</p> <p>pages 69-72</p> <p>pages 77-80</p> <p>pages 93, 94</p>	<p>On page 9, changed the exclusion period of time for retroactive SS benefits received on or after 11-01-05. Pages 10 and 13 are reprinted. On page 14, changed the exclusion period of time for retroactive SS benefits received on or after 11-01-05. Page 17 is reprinted. Added new Spousal Resource Standard and Maximum Spousal Resource Standard on page 18. On page 65, replaced the term “program designation” by “aid category” or “AC.” On page 66, updated the Maximum Monthly Maintenance Needs Allowance and Utility Standard Deduction. On page 69, deleted the special earnings allowance in item 1 for MR Waiver patients because it is obsolete. On pages 69 and 70, deleted example 19, added the DS Waiver, updated the reference to the EDCD Waiver, and deleted the reference to CDPAS Waiver, and. Page 71 is a runover page. Page 72 is reprinted. On page 77, changed references to</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
		social security benefits to “SS.” On page 78, clarified the policy about no patient pay for MN ICF-MR and IMD patients. Page 79 is a runover page. Pages 80 and 93 are reprinted. On page 94, added the DS Waiver, and clarified where to send the DMAS-122 form.
Subchapter M1510 pages 1, 2	Subchapter M1510 pages 1, 2	On page 1, added a section and correct a section number. Page 2 is reprinted.
Subchapter M1520 pages 5, 6 pages 17-22	Subchapter M1520 pages 5, 6 pages 17-22	On page 5, clarified the renewal verification requirements. Page 6 is a runover page. On pages 17-22, updated the MMIS follow-up fields and codes, replaced the term “program designation” with “aid category” or “AC,” and replaced “special review” with “follow-up.”
Chapter M18 pages 1, 2 pages 7, 8 pages 11, 12	Chapter M18 pages 1, 2 pages 7, 8 pages 11, 12	On page 1, deleted all references to a monthly Medicaid card, added description of the plastic Medicaid card, and updated the list of individuals who do not receive a card. On page 2, updated the nursing facility patients’ section. Page 7 is reprinted. On page 8, updated the Client Medical Management section. Page 11 is reprinted. On page 12, updated the list of waivers.
Chapter M21 Table of Contents pages 1-4a pages 5, 6 pages 9 -11 Appendix 2, pages 1-2 Appendix 3, pages 1-3 Appendix 4, pages 1-6 Appendix 5, pages 1-2 Appendix 6, page 1 Appendix 7, pages 1-2	Chapter M21 Table of Contents pages 1-4 pages 5, 6 pages 9 -11 Appendix 2, pages 1-3 Appendix 3, page 1 Appendix 4, pages 1-2	Updated the Table of Contents. Page 1 is a runover page. On page 2, deleted the “Local Choice” reference. On page 3, deleted the “Local Choice” reference. On page 4, added Medicare, Medicaid and State/Local Hospitalization to the list of items that are not health benefit plans. Page 4a is deleted. On page 5, deleted “Local Choice” reference.

Remove and Destroy Pages

Insert Attached Pages

Significant Changes

Chapter M22
Table of Contents
pages 1-4
pages 7-8

Chapter M22
Table of Contents
pages 1-4
pages 7-9

On page 6, added “FAMIS Select” to the list of plans that are not considered insurance for FAMIS eligibility purposes. On page 9, added a leading zero to the aid categories. On page 10, updated the documents to include in a FAMIS case transferred to the CPU. On pages 10 and 11, replaced the references to ESHI with “FAMIS Select,” the new premium assistance component of FAMIS. Deleted Appendixes 2, 4, and 5. Renumbered the remaining appendixes, the “Virginia State Agencies”, the revised “Children’s Health Insurance Communication Form” and the “FAMIS Alien Eligibility Chart.”

Updated the Table of Contents. On page 1, deleted the word “solely.” On page 2, clarified the nonfinancial requirements and added the application for other benefits requirement. Updated the appendices references on page 3. On page 4, added Medicare, Medicaid and State/Local Hospitalization to the list of items that are not health benefit plans. On page 7, added the aid category processing order for a pregnant woman, and revised the notification requirements. Page 8 is a runover page. On page 9, clarified the notification requirements.

Please retain this transmittal letter in the back of Volume XIII.



S. Duke Storen, Director
Division of Benefit Programs

Attachment

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Medicaid Application for Medically Indigent Pregnant Women, form #032-03-040.....	Appendix 5.....	1
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**C. Applicants Under
Age 18**

1. Child Applicant

A child who is under age 18 years is not legally able to sign a Medicaid application for himself unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whoever is caring for the child is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 days, send a notice to the applicant to extend the pending application.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Child Welfare service worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian or custodial adult and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child

a. Non-IV-E

The Medicaid application for a *non-IV-E* child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, the parent or legal guardian must sign the Medicaid application.

b. IV-E

A separate Medicaid application is not required for a child in the custody of a Virginia public or private child-placing agency whose IV-E eligibility has been evaluated using the Title IV-E Foster Care and Medicaid Application/Redetermination. If there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.

4. Adoption Assistance & Special Medical Needs Children

a. Placed by a Virginia Agency

A separate Medicaid application is not required for a IV-E adoption assistance child. A Medicaid application is required for all other adoption assistance children.

b. Placed by Another State

IV-E and non-IV-E special medical needs children who have been placed for adoption by another state through ICAMA should have a form 6.01

which verifies eligibility for Medicaid and a separate application is not required. All states and territories EXCEPT New York, Vermont, Wyoming, Puerto Rico and Virgin Islands are members of ICAMA.

A Medicaid application is required for all other adoption assistance children.

D. Deceased Applicant

1. An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions are met:
 - the deceased received a Medicaid-covered service on or before the date of death, and
 - the date of service was within a month covered by the Medicaid application.
2. If the above conditions are met, an application may be made by any of the following:
 - his guardian or conservator,
 - attorney-in-fact,
 - executor or administrator of his estate,
 - his surviving spouse, or
 - his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

E. Unsigned Application

An application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

F. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

M0120.300 Medicaid Application Forms

A. General Principle

A signed application is required for all initial requests for medical assistance, *except for*:

- *IV-E Foster Care children in the custody of a Virginia public or private agency,*
- *IV-E Adoption Assistance & Non-IV-E Special Medical Needs Children placed by a Virginia public or private child-placing agency,*
- *IV-E Foster Care children from an ICAMA member state or territory,*
- *IV-E Adoption Assistance & Non-IV-E Special Medical Needs Children placed by an ICAMA member state or territory,*

The Request for Assistance--ADAPT--, form #032-03-875 (see M0120, Appendix 2) may be used to establish and preserve the application date, but a signed application must be submitted in order for eligibility to be determined.

A child born to a mother who was Medicaid eligible at the time of the child's birth, including a child born to an emergency services alien certified for Medicaid payment for labor and delivery, is deemed to have applied and been found eligible for Medicaid on the date of the child's birth. An application for the child is not required. The child remains eligible for Medicaid to age 1 year so long as the mother remains eligible for Medicaid, or would be eligible if she were still pregnant, and they live together.

B. Medicaid Application Forms

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including medically indigent pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination.

Appendices 3 through 8 of this chapter contain sample prescribed Medicaid application forms. Other forms that serve as Medicaid application forms are listed in section M0120.300.D.

The following forms have been prescribed as application forms for Medicaid:

- Application for Benefits, form #032-03-824, also referred to as the Combined application, may be used by any applicant (see M0120, Appendix 3).
- Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (see M0120, Appendix 4);

- Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (see M0120, Appendix 5);
- Health Insurance for Children and Pregnant Women, form FAMIS-2 (see M0120, Appendix 6);
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. This form is not to be given to applicants by the local departments of social services (M0120, Appendix 7 is provided for reference purposes);
- Signed ADAPT Statement of Facts (SOF). If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant and attached to the SOF.
- Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (see M0120, Appendix 8).

M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. *Qualified Individuals (QI)*

Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. A QI must submit a new Medicaid application on or after January 1 of each year in order to receive continued coverage. Applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).

C. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf. The application may be received by mail, fax, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency's business hours, the date of the application is the next business day.

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.



Health Insurance for Children and Pregnant Women

This application is for Virginia's health insurance programs for children and pregnant women. FAMIS and FAMIS Plus cover children, FAMIS MOMS and Medicaid cover pregnant women.



Step 1

Tell us who is completing the application, where you live, and where you get your mail:

Application: ☐ New ☐ Renewal
Family ID # _____
Case Worker _____

First Name	MI	Last Name	Phone Numbers	Preferred Language (See Instructions)
			H () W () Other ()	
Address		Apt. No.	City	State
(Street)				ZIP
(Mailing)				City/County of Residence

Step 2

Tell us if anyone applying for health insurance is pregnant:
Proof of pregnancy and due date are required. See instructions.

First Name	MI	Last Name	Expected Due Date
			(Month/Day/Year)

Step 3

Tell us about all the children and pregnant women under 21 living in your home:
If there are more than four children in the home, please complete steps 3 and 4 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (First, MI, Last)				
Relationship to You				
Date of Birth & Sex	month / day / year <input type="checkbox"/> M <input type="checkbox"/> F	month / day / year <input type="checkbox"/> M <input type="checkbox"/> F	month / day / year <input type="checkbox"/> M <input type="checkbox"/> F	month / day / year <input type="checkbox"/> M <input type="checkbox"/> F
Child's Parent, Stepparent or Spouse Living in the Home (First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required
	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Spouse Name: _____ (SS#) _____ Not Required

Step 4

Tell us about the children under 19 and pregnant women under 21 applying for insurance:

	Child 1 <i>continued</i>	Child 2 <i>continued</i>	Child 3 <i>continued</i>	Child 4 <i>continued</i>
Child's Full Name (First, MI, Last)				
Applying for Health Insurance for Child?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you are applying for insurance for this child, answer the questions below. If you are not applying for this child, you may go to Step 5.				
Is Child a U.S. Citizen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child's SS# or date of application for SS#	If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____ (SS#)	If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____ (SS#)	If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____ (SS#)	If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____ (SS#)
Child Attends School?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child's Race (See codes below)	Race Code # _____ RACE CODES: 1 White; 2 Black/African American; 3 American Indian/Alaskan Native; 4 Asian; 5 Spanish American/Hispanic; 6 Native Hawaiian or Other Pacific Islander; 7 Asian & White; 8 Black/African American & White; 9 Other or Unknown; or A Asian & Black/African American	Race Code # _____	Race Code # _____	Race Code # _____
Child's Ethnicity	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason# _____ Other _____	Reason# _____ Other _____	Reason# _____ Other _____	Reason# _____ Other _____
REASONS CHILD'S HEALTH INSURANCE ENDED. (See instructions) 1 Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. 2 Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. 3 Insurance company discontinued coverage because child is uninsurable. 4 Cost of insurance exceeded 10% of monthly income (before taxes). 5 Insurance stopped/dropped by someone other than parent or stepparent living with child. 6 Stopped/dropped a COBRA policy. 7 Other:				

Step 5

Tell us about pregnant women 21 and over applying for insurance:
 If not applying for an adult pregnant woman, you may go to Step 6.

Full Name (First, MI, Last)		Applying for Health Insurance for a Pregnant Woman? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Her Date of Birth month / day / year	Her Relationship to You:	Provide Full Name of Husband if Living in the Home:	
Is the Pregnant Woman a US Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	If No, please provide: Alien/INS# _____ Country of Birth _____ Date Entered U.S. _____	SS#: _____ Race: (see codes below) Race Code# _____	Ethnicity: Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO
RACE CODES: 1 White; 2 Black/African American; 3 American Indian/Alaskan Native; 4 Asian; 5 Spanish American/Hispanic; 6 Native Hawaiian or Other Pacific Islander; 7 Asian & White; 8 Black/African American & White; 9 Other or Unknown; or A Asian & Black/African American			
Does Pregnant Woman Have Health Insurance Now? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please provide: Type of Policy _____ Company Name _____	Policy ID # _____	

Step 6

Tell us about household income:
 Complete the section below for each parent, stepparent, child, pregnant woman, and spouse living in the home and receiving income. List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "NONE" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)
May we have your permission to get information from all employers, if necessary, about dates of employment and earnings? ☐ YES ☐ NO

Person Receiving Income	Employer's Name or Source of Income	How Often is Income Received?	How Much Gross Income is Received?
(First Name, MI, Last Name)	Employed by the state? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$
(First Name, MI, Last Name)	Employed by the state? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$
(First Name, MI, Last Name)	Employed by the state? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$
(First Name, MI, Last Name)	Employed by the state? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	\$

FAMIS Select: FAMIS offers help with private health insurance premiums through FAMIS Select.
 If your child is approved for FAMIS you may choose to enroll your child in a private or employer health insurance plan instead of FAMIS.
FAMIS Select may help you pay for it.

☐ If my child is approved for FAMIS, I would like more information about **FAMIS Select**.

You are almost done. Turn the page over, complete the application, and remember to sign it.

Step 7**Tell us about childcare or adult daycare expenses:**

Do you pay someone to provide childcare or adult daycare while you work?

☐ YES ☐ NO

	Person 1	Person 2	Person 3	Person 4
Full Name of person in daycare				
How much do you pay? How often?				

Step 8**Tell us about medical bills in the last 3 months:**

If the child or pregnant woman is eligible, FAMIS Plus or Medicaid for pregnant women may be able to help you with medical/dental services in the last 3 months. Did any child or pregnant woman you are applying for receive medical/dental services in the last 3 months? ☐ YES ☐ NO

If **Yes**, list names of the children or the pregnant woman and the months in which they received medical/dental services.
(Note: Dental services are only covered for children.)

You must provide proof of household income for the months that the child or pregnant woman received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS.**

Step 9**Tell us if you have authorized someone else to follow up on this application:**

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____ and/or (organization name) _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____

to receive eligibility and enrollment information relating to my child(ren) or the pregnant woman on this application. I also authorize FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

Step 10**Signature: We cannot process this application unless it is signed.**

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all the information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, health insurance coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

SIGNATURE **(REQUIRED)**

DATE

Application Instructions & Rights and Responsibilities

This Application May Be Used For: FAMIS or FAMIS Plus for Children and FAMIS MOMS and Medicaid for Pregnant Women

(FAMIS Plus is the new name for children's Medicaid)

How do I apply?

To get started, simply call our toll-free number **1-866-87-FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS at PO Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off, or faxed to the **local Department of Social Services** in the city or county in which you live. Check the blue pages in your telephone book for the address and telephone number of your local Department of Social Services. It is not required that you visit FAMIS or your local Department of Social Services to apply. You may also apply online at **www.famis.org**.

For a child or a pregnant woman under 21:

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse. Children and pregnant women 18 and over or children emancipated by a court may apply for themselves.

For a pregnant woman over 21:

An adult pregnant woman may apply for herself. The adult husband of a pregnant woman, guardian, or an adult relative if the pregnant woman cannot sign for herself may apply on her behalf.

Step 1 Information on person completing application: Complete this section listing your name, address, city/county of residence and phone number. If we may call you at work, include that phone number. Please tell us what language you prefer. Write the name of the language you prefer in the space provided, such as: English, Spanish, Cambodian, Vietnamese, Farsi, Haitian-Creole, Laotian, Chinese, Korean, Somali, Kurdish, Arabic, French, German, Japanese, or any other language.

Step 2 Information on pregnant applicant: Complete this section if you are applying for insurance for someone who is pregnant. Write her name and expected due date. Attach proof of pregnancy from her health care provider to the application.

Step 3 Information on all children and pregnant women under 21: Provide information on all children and pregnant women under 21 who live in the home with you even if they are not applying for **FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid for pregnant women**. Although you can only apply for children under age 19 and pregnant women on this form, we need information on all children under 21 living in your home to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete steps 3 and 4 on the Additional Child Form or on another application and attach it to this one. For each child under age 21 in the home please write the child's name, your child's relationship to you, the child's date of birth and check if the child is male or female. Write the name of the child's parents, stepparent, and spouse living in the home and check their relationship to the child. The Social Security Number (SS#) of the parent, stepparent and spouse is helpful, but not required information. If you are applying for a pregnant woman under age 21, include all of the same information.

Step 4 Information about children under 19 and pregnant women under age 21 applying for insurance:

Write the **name** of each person under 21 at the top of the same column again. Check whether you are **applying for health insurance** for each child or pregnant woman under 21. Answer all the questions in the column, if you are applying for health insurance for this person.

If the child or pregnant woman under age 21 is a **U.S. citizen** check yes. If they are **legal immigrants**, provide the child's Alien/INS #, country of birth and the date they entered the U.S. Some legal residents may qualify for these health insurance programs. You must provide a copy of the front and back of the child's/pregnant woman's Resident Alien Card or other proof of immigration status with this application. Your immigration status will not be shared with the

INS. We do not need information on the immigration status of any adults in your family if they are not applying for health insurance. The INS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Tell us if the child is currently **attending school**.

Enter the correct code number for the person's **Race**. Codes are listed below the question on the application. Then check yes or no if they are of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus or a pregnant woman's eligibility for Medicaid but may affect eligibility for FAMIS and FAMIS MOMS. Tell us if the person has **health insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless they are pregnant or there was a "good cause" reason the health insurance ended. If the child had **health insurance during the past 4 months**, tell us about the policy. Please list the type of policy, name of insurance company, the policy number of the previous health insurance, and the date that it ended. Read the **good cause reasons for ending health insurance** listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation of the good cause reasons or more information on what to include with the application, call **1-866-87-FAMIS** or your **local Department of Social Services**. **This rule does not apply to FAMIS Plus.**

If you are applying for a **pregnant woman under 21**, you do not need to provide information about health insurance in the last four months and may skip to the next step.

Step 5 Pregnant Women 21 and over applying for insurance: Write the full **name** of the pregnant woman and check if applying for health insurance. Include her date of birth, her relationship to you (self, spouse, daughter, etc.), and her husband's full name, if he resides in the home.

If the pregnant woman is a **U.S. citizen** check yes. If the woman is a **legal immigrant**, provide the woman's Alien/INS #, country of birth and the date the woman entered the U.S. Some adults who are legal residents may qualify for these health insurance programs. **You must provide a copy of the front and back of the woman's Resident Alien Card or other proof of immigration status with this application.**

A **Social Security Number** is required for all pregnant women applying for health insurance.

Enter the correct code number for the **Race and Ethnicity** of the pregnant woman. Codes are listed below the question on the application. Then check yes or no if the woman is of Hispanic/Latino ethnic origin.

Check if the woman currently has health insurance. If yes, indicate the type of policy, company name and policy identification number.

Step 6 Household Income: In some situations we may need to contact employers to get information about dates of employment and earnings. If you agree to let us do this in order to process this application, check yes.

For each parent, stepparent, pregnant woman, spouse, and child under 21 who lives in the home and receives income, list their **name and the source of income**. If the income is from a job, list the name of the employer. If the income is from another source (such as child support, unemployment compensation, Social Security, etc) write the type or source of the income. Check yes if the person works for a **State government**.

For each type of income listed, check how often it is received (**each week, every two weeks, twice a month, once a month, or yearly**) and write the gross amount of income received each time. **Be sure to write the amount of income before any taxes or other deductions are taken (gross income).**

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To **provide proof of income from a job**, please attach a copy of all paycheck stubs for the month before you apply showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much (gross pay) the employee was paid for each pay period for that month or you may call 1-866-87-FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or provide business records for last month.

You must also provide proof of other types of income received. Examples of **proof of other income** include:

- Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, a signed statement from the absent parent stating how much they pay each month, or a recent court order;
- Social Security (SSA or SSI) or Veteran's benefits — the current year award letter from the Social Security Administration or the VA;
- Unemployment compensation — a print out from the Employment Commission of all payments for the last month, benefits award letter, or a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call **1-866-87-FAMIS** or your **local Department of Social Services**

FAMIS Select: If your child(ren) are approved for FAMIS, you may choose to enroll them in a private or employer sponsored health insurance plan. FAMIS Select can help with the premiums. If you are interested in this program check the box and we will mail you additional information if your child is approved for FAMIS.

Step 7 Childcare or Adult Daycare Expenses: Certain child and adult daycare expenses may help a person qualify for FAMIS Plus or Medicaid for pregnant women. Tell us if you **pay for childcare or adult daycare while** you work. If the answer is yes, write the **name** of each person in daycare and how much you pay for their care and how often you pay it. (For example: \$50 a week or \$200 a month.) You can even report this expense if you are paying a relative to care for the children. The adult daycare expenses must be for an incapacitated spouse or parent of the person applying for health insurance.

Step 8 Medical Bills in the Last 3 Months: If a child qualifies for FAMIS Plus or a pregnant woman qualifies for Medicaid, you may be able to get help with **medical and dental bills for the past 3 months (dental bills are only covered for children)**. Tell us if a child or pregnant woman applying for insurance has any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or pregnant woman who has medical bills and the **month** in which they received the medical or dental service. You will also have to show proof of family income for that month so we can determine if they would have qualified for FAMIS Plus or Medicaid at the time the medical care was received. If a child qualifies for FAMIS or a pregnant woman qualifies for FAMIS MOMS, medical bills will only be covered from the first day of the month in which your signed application was received by FAMIS or at the local Department of Social Services.

DO NOT SEND MEDICAL OR DENTAL BILLS. We cannot pay for bills sent from individuals. If the child or pregnant woman qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the FAMIS Plus child or Medicaid Pregnant woman during that time.

Step 9 Release of Information: If you would like someone else to be able to receive information about this application on your behalf, **clearly print the person's name** or the name of an **organization, the address, and phone number** in this section. We will not release any information about this application to anyone except you or your spouse living in the home, unless you tell us who you want to be able to receive this information.

Step 10 Signature: Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an application without a signature.

Final checklist:

- ☐ Did you answer all the questions?
- ☐ Did you attach proof of all of last month's income?
- ☐ Did you attach any other necessary documents?
- ☐ Did you sign the application?

Mail to FAMIS at PO Box 1820, Richmond, VA 23218-1820 or fax to FAMIS at 1-888-221-9402 or drop it off at your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES (Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law. I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects eligibility for or receipt of FAMIS, FAMIS Plus (children's Medicaid), FAMIS MOMS, or Medicaid for pregnant women. This includes timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole reason is for lack of funding for FAMIS or FAMIS MOMS.
- Receive services from the Division of Child Support Enforcement (DCSE) and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus. I also understand that if an adult pregnant woman is found eligible for Medicaid, has children, and is separated or divorced from her husband, she may be required to cooperate with DCSE to receive benefits.

I further understand and agree that:

- This application could lead to enrollment in FAMIS or FAMIS Plus for the children or FAMIS MOMS or Medicaid if the person applying is pregnant. I understand that they will be enrolled in the appropriate program based on eligibility rules.
- The children are **not eligible** for FAMIS or FAMIS MOMS coverage if:
 - they are eligible for FAMIS Plus or Medicaid for pregnant women;
 - they are eligible for health coverage under a State Employee Health Insurance Plan;
 - they are patients in an institution for mental diseases; or
 - they are inmates in a public correctional institution.
- The State and its contractors may contact other State and Federal agencies to verify any information that affects eligibility for coverage of the children or pregnant woman applied for on this application.
- The State and its contractors may exchange information on this application and medical, health, or other information relating to the child(ren)'s or pregnant woman's coverage with other agencies and contractors to assist with application, enrollment, administration, quality control, and quality assurance. This includes companies offering health insurance to the child(ren) or pregnant women. We will not share your information with the IRS or the INS.
- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by the child(ren) or pregnant woman.
- Each provider of medical services to the child(ren) or pregnant woman may release any medical or other information necessary for the provider to be paid.

As an enrollee in FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid, I understand:

- I will be responsible for paying a co-payment for some FAMIS medical and dental services received by my child(ren);
- I may be responsible for paying co-payments for non-pregnancy related services for the pregnant woman enrolled in FAMIS MOMS or Medicaid;
- That FAMIS Plus cases for children and Medicaid for pregnant women cases, will be maintained by the local Department of Social Services where the person lives;
- That FAMIS and FAMIS MOMS cases will be maintained by the FAMIS Central Processing Unit (CPU);
- That for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months; and
- I must report any changes in the information provided on this application to the FAMIS CPU at 1-866-873-2647 or my local Department of Social Services agency.

FAMIS AND FAMIS PLUS MUST BE RENEWED AT LEAST **EVERY 12 MONTHS**. IT IS VERY IMPORTANT THAT YOU REPORT ANY CHANGE IN YOUR ADDRESS TO THE AGENCY THAT IS MANAGING THE CASE. IF WE DO NOT HAVE A CORRECT ADDRESS, WE WILL NOT BE ABLE TO NOTIFY YOU WHEN IT IS TIME TO RENEW COVERAGE AND THE CHILD WILL BE CANCELLED FROM THE PROGRAM.

HELP US KEEP YOUR CHILDREN COVERED — TELL US IF YOU MOVE!

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**4. Time Standard
Exceptions**

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,
- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

**C. Application for
Retroactive
Coverage**

When an applicant for Medicaid reports that he, or anyone for whom he requests assistance, received a medical service within the three months prior to application, retroactive Medicaid eligibility must be determined. The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the three months prior to the application month. The applicant must provide all verifications necessary to determine eligibility during that period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (see M1510, Appendix 1).

Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number or application for the number, and date of birth.

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied or the coverage cancelled due to the inability to determine eligibility.

C. Verification of Nonfinancial Eligibility Requirements

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

- Virginia state residency,
- application for other benefits,
- institutional status,
- *citizenship and age for children under age 19,*
- Social Security number (see section D below),
- health insurance information (see sections E and F below), *and*
- *dependent child information for individuals applying as parents or the caretaker-relative of a dependent child.*

The following information must be verified:

- *citizenship or legal presence in the U.S. of applicants age 19 or older;*
- *age of applicants age 65 and older;*
- *disability and blindness; and*
- *pregnancy.*

See item E. below for instructions on the verification of citizenship/legal presence. See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

If an SSN has not been issued, the applicant must cooperate in applying for such a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be *entered in the MMIS*. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not born to a Medicaid-eligible woman, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

Exceptions:

- Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met, *as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together.* A child eligible in this category does not need a Social Security number.
- Aliens who are eligible *only* for Medicaid *payment of* emergency services are not required to provide or apply for SSNs (see M0220).

E. Legal Presence (Effective January 1, 2006)

*Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.***

An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

1. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- *valid evidence of U.S. citizenship;*
- *valid evidence of legal permanent resident status;*
- *valid evidence of conditional resident alien status;*
- *a valid SSN verified by SSA;*
- *a U.S. non-immigrant visa;*
- *a pending or approved application for legal asylum;*
- *a refugee or temporary protected status document; or*
- *a pending application for an adjustment of residence status.*

2. Failure to Provide Proof of Legal Presence

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- *a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or*
- *indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.*

*The affidavit form is in Appendix 2 to this subchapter. NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.*

3. Relationship to Other Medicaid Requirements

*Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.*

F. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must forward the information to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

**G. Health Insurance
Payment Program
(HIPP)**

If a member of the assistance unit is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan *the HIPP Application and Medical History Questionnaire must be completed by the applicant. The Insurance Verification Form must be given to the applicant/recipient for completion by the employer* (see M0290).

**H. Verification of
Financial
Eligibility
Requirements**

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information *for individuals in need of long-term care services*, including the date of transfer, asset value, and compensation received.

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the State Verification Exchange System (SVES) or State Online Query system (SOLQ) cannot be used. If the SDX system is used to verify benefits, the case record must be documented to show why SVES or SOLQ was not used.

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

M0130.300 Eligibility Determination Process

**A. Evaluation of
Eligibility
Requirements**

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

The evaluation of eligibility requirements must be documented in writing. The ADAPT Verification Form (#032-03-366) or the Evaluation of Eligibility (form #032-03-823) may be used. The forms are available online at <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>.

Agency-created evaluation forms are acceptable as long as all information needed to determine eligibility is documented in ADAPT or on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.

- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the general principles of Medicaid Eligibility determination.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering partial coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

2. Enrollment

Medicaid cases must be enrolled in the Medicaid Management Information System (MMIS). Effective June 16, 2003, a new MMIS system was implemented. The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the *current* MMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:

- The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit "0." (e.g. AC 051).
- Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.
- The former cancel reasons are now prefaced by the digit "0" (e.g. cancel reason 007).

When enrolling an individual in *the* MMIS, the appropriate aid category (AC) for the applicant's covered group must be used. Enrollment procedures and a list of ACs are found in the Virginia MMIS User Manual.

**3. Notification
to Applicant**

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (see M0130, Appendix 1) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;
- the retroactive Medicaid coverage was approved, including the effective dates;
- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;
- there is a reason for delay in processing his application;
- a request for re-evaluation of an application in spenddown status has been completed; and
- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

**E. Notification for
Retroactive
Entitlement**

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

**A. General
Principle**

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request must be written and documented in the record. When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid.

An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement specifically indicating the wish to withdraw the retroactive coverage part of the application.



COMMONWEALTH of VIRGINIA

**AFFIDAVIT OF UNITED STATES CITIZENSHIP OR LEGAL
PRESENCE IN THE UNITED STATES**

I understand that providing proof of my United States citizenship or legal presence in the United States is a requirement for receipt of Virginia Medicaid benefits. I declare, under penalty of perjury, that I am a United States citizen or am legally present in the United States.

I understand that if I give false information regarding my United States citizenship or legal presence in the United States, my Virginia Medicaid coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

Print Name _____

Signature _____ Date _____

Residence Address _____ Telephone _____

City _____ State _____ ZIP _____

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M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0210.000 GENERAL RULES AND PRINCIPLES

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M0210.000 GENERAL RULES & PROCEDURES**M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION****A. Introduction**

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups *for which he meets the definition*, and the applicant/recipient shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

- a. *Legal presence in the U.S., effective January 1, 2006 (M0250.150).*
- b. Citizenship/alien status (M0220).
- c. Virginia residency (M0230).
- d. Social Security number (SSN) provision/application requirements (M0240).
- e. Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (M0250).
- f. Application for other benefits (M0270).
- g. Institutional status requirements (M0280).
- h. Application to the Health Insurance Premium Payment Program (HIPP) (M0290).
- i. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

- a. Asset transfer for individuals *who need long-term care* (subchapter M1450).
- b. Resources within resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).
- c. Income within income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups).

3. Example

EXAMPLE: *On January 5, 2006, Mr. H applies for Medicaid. He is in a nursing facility in Virginia, and has been there since July 5, 2005. When evaluating his application, the worker finds that he:*

- is a U.S. citizen,
- is currently a Virginia resident residing in a medical institution in Virginia,
- *provided* his SSN,
- refused to provide third party liability and medical support information,
- has applied for all benefits to which he is entitled,
- meets the institutional status requirements,
- is not required to apply to the HIPPA Program,
- is age 67 years and meets a covered group requirement.

He currently has \$5,000 in the bank. His income is \$600 per month Social Security (SS). *Since he refused to provide third party liability and medical support information, he does not meet the assignment of right requirements and his application must be denied.* He is also informed of the resource limit and that he is ineligible for Medicaid because his resources exceed the limit.

M0210.100 INELIGIBLE PERSONS**A. Introduction**

The individuals listed in this section are not eligible for Medicaid. However, their income and resources may be considered in determining the eligibility of others in the household who have applied for Medicaid.

B. Certain Recipients of General Relief (GR)

A recipient of General Relief maintenance who does not meet a Medicaid covered group is not eligible for Medicaid.

An applicant for Medicaid and *Supplemental Security Income* (SSI) who receives GR from the interim assistance component may become eligible for Medicaid following the establishment of SSI eligibility. Eligibility for an SSI payment is effective the month **following** the SSI application month. When the Medicaid application is dated in the same month as the SSI application, Medicaid eligibility can be effective the month of application if the applicant meets all Medicaid eligibility requirements and another covered group requirement in the application month.

C. Essential Spouse of an ABD Individual

An essential spouse of an aged, blind, or disabled person who does not himself/herself meet a covered group is not eligible for Medicaid.

D. Individual Who Refuses to Assign Rights

An individual, who refuses to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.

- E. Individual Who Refuses to Pursue Support From an Absent Parent** An individual, other than a medically indigent pregnant woman, applying for Medicaid for herself and on behalf of a child who refuses to cooperate in the pursuit of support from an absent parent, is not eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.
- F. Individual Found Guilty of Medicaid Fraud** An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.
- G. Individual Who Has Transferred Property** An individual who transferred property:
- to become or remain eligible for Medicaid,
 - who did not receive adequate compensation, and
 - who did not meet one of the asset transfer exceptions
- is ineligible for Medicaid or Medicaid payment for long-term care services for a specified period of time unless adequate compensation is received before the time period is over. See Chapter M1450 for asset transfer policy.
- H. Individual Who Refuses to Supply or Apply For an SSN** Any individual, except a child under age 1 born to a Medicaid-eligible mother or an illegal alien, who does not apply for an SSN account number or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for Medicaid.

M0210.150 LEGAL PRESENCE

- A. Legal Presence (Effective January 1, 2006)** *Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are exempt from this requirement. Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.*
- An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.*
- B. Documents That Demonstrate Legal Presence** *An applicant may demonstrate legal presence by presenting one of the following documents:*
- valid evidence of U.S. citizenship;
 - valid evidence of legal permanent resident status;
 - valid evidence of conditional resident alien status;
 - a valid SSN verified by the Social Security Administration (SSA);
 - a U.S. non-immigrant visa;
 - a Resident Alien Card, form I-551, showing lawful permanent residence (green card);
 - a pending or approved application for legal asylum;

- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**C. Failure to Provide
Proof of Legal
Presence**

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

*The affidavit form is in Appendix 2 to this subchapter. NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.*

**D. Relationship to
Other Medicaid
Requirements**

*Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.*

M0210.200 COVERED GROUPS

A. Introduction

An individual who meets the nonfinancial eligibility requirements must also meet the definition for a Medicaid covered group. Covered groups include individuals who are age 65 or older, blind, disabled, under age 19, pregnant women, and the parent(s) or caretaker-relative of a dependent child. Medicaid financial eligibility requirements vary depending upon the covered group for which eligibility is being determined.

See chapter M03 for the covered groups' definitions, policy and procedures.

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS**M0220.001 GENERAL PRINCIPLES****A. Introduction**

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non citizens of the U.S.. These changes eliminated the permanently residing under color of law (PRUCOL) category of aliens. The level of Medicaid benefits for aliens is based on whether the alien is a “qualified” alien and the alien’s date of entry into the U.S.

As a result of these federal changes in Medicaid eligibility for aliens, the 1997 Virginia General Assembly enacted legislation to protect Medicaid eligibility for certain aliens who would otherwise lose their Medicaid benefits.

This subchapter (M0220), effective on July 1, 1997, explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as “full benefit aliens”) or emergency services only (referred to as “emergency services aliens”). It contains the entitlement and enrollment procedures for full benefit aliens and emergency services aliens who meet all other Medicaid eligibility requirements.

**B. Declaration of
Citizenship/Alien
Status**

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. *The declaration statement is on the application form.*

EXCEPTION: An individual who is an “unqualified” alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

C. Procedures

The policy and procedures for determining whether an individual is a citizen or a “full benefit” or an “emergency services” alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status;
M0220.300 Full Benefit Aliens;
M0220.400 Emergency Services Aliens;
M0220.500 Aliens Eligibility Requirements;
M0220.600 Full Benefit Aliens Entitlement & Enrollment;
M0220.700 Emergency Services Aliens Entitlement & Enrollment.

M0220.100 CITIZENSHIP AND NATURALIZATION**A. Introduction**

A citizen or naturalized citizen of the U.S. meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

B. Procedures**1. Individual
Born in the
U.S.**

An individual born in the United States, any of its territories (Guam, Puerto Rico, U.S. Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is presumed to be a citizen unless there is reason to question. If questionable, citizenship is verified by the individual's birth certificate or U.S. Passport. If such documents are not available, a signed statement of another person attesting to the individual's place of birth if in the U.S. is acceptable verification.

NOTE: A child born in the U.S. to non-citizen parents who are in the U.S. as employees of a foreign country's government may not meet the U.S. citizen requirement. When a child born in the U.S. to non-citizen parents is a U.S. citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the U.S.

**2. Individual
Born Outside
the U.S.****a. Individual Born to or Adopted by U.S. Citizen Parents**

A child or individual born outside the United States to U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. *A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child, and does not have to apply for citizenship.*

b. Individual Born to Naturalized Parents

A child born outside the United States to alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

c. Naturalized Individual

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above, must have been naturalized to be considered a citizen.

- f. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;
- g. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.
- h. *is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his/her intent to reside in Virginia permanently or for an indefinite period of time.*

**B. Under Age 21 In
An Institution**

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

- 1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
- 2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or
- 3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the party who files the Medicaid application resides in Virginia.
- 4. for an individual under 21, if a legal guardian has been appointed for the child and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

M0230.202 INDIVIDUALS AGE 21 OR OLDER

A. Introduction

For an individual age 21 or older, the determination of state residency depends on

- whether or not the individual is in an institution, and
- whether or not the individual is capable of indicating his or her intent to reside in the state.

**B. Age 21 Or Older
NOT In An
Institution**

For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:

- the individual is living in Virginia with the intention to remain in Virginia permanently or for an indefinite period;

- the individual is incapable of indicating intent and the individual is living in Virginia; or
- the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).

**C. Age 21 Or Older
In An Institution**

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

**1. Capable of
Stating Intent**

An individual in an institution who is age 21 or over and who is capable of declaring his intent to reside in Virginia, is a resident of Virginia if the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period.

**2. Became
Incapable
Before Age 21**

An individual in an institution who is age 21 or over and who became incapable of stating intent before age 21 is a Virginia resident if:

- regardless of the physical location where the individual actually resides, Virginia is the individual's state of residence when the individual's legal guardian or parent who files the Medicaid application resides in Virginia;
- the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
- the individual's parent or legal guardian who applies for Medicaid resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia and the party who files the Medicaid application resides in Virginia.

If a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

**3. Became
Incapable At
or After Age
21**

An individual in an institution who is age 21 or over and who became incapable of stating intent at or after age 21 is a Virginia resident if he or she is residing in Virginia and was not placed here by another state.

M0230.203 STATE PLACEMENT IN INSTITUTION

A. Policy

Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state, is recognized as acting on behalf of the state in making the placement. The

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLE

- A. Policy** To be eligible for Medicaid, an individual must provide his/her Social Security number (SSN) as well as the SSNs of any children for whom Medicaid is requested, or must provide proof of application for an SSN, UNLESS the applicant
- is an illegal alien as defined in subchapter M0220, or
 - is a child under age 1 as defined in M0320.301 B. 2.
- B. Failure to Meet This Requirement** Any Medicaid family unit member for whom an application for a SSN has not been filed or for whom the SSN is not furnished is **not eligible** for Medicaid EXCEPT for:
1. a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.
 2. an illegal alien as defined in Section M0220; an illegal alien does not have to provide or apply for a SSN.
- C. Relationship to Other Medicaid Requirements** *An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for a SSN does NOT meet the SSN requirement.***
- D. Verification** The individual's SSN *must be verified by the Social Security Administration (SSA).*
- E. Procedure** Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have a SSN.

M0240.100 APPLICATION FOR SSN

- A. Policy** If a SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office. *An Enumeration Referral Form, form #032-03-400, must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the Medicaid Management Information System (MMIS).*

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that a SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application.

Applicants who refuse to furnish a SSN or to show proof of application for a number are ineligible for Medicaid.

**B. Failure to Meet
This Requirement**

Any Medicaid family unit member for whom a SSN has not been applied is **not eligible** for Medicaid EXCEPT for:

1. a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.
2. an illegal alien as defined in Section M0220; an illegal alien does not have to provide or apply for a SSN.

C. F&C Covered Groups

A child who is **temporarily** living away from his/her parent's home is considered living with the parent and the family unit policy in subchapter M0520 applies.

If the child is living apart from the parent or is receiving LTC services, only the income and resources which the parent actually makes available to the child are counted.

M0250.500 SUPPORT FROM ABSENT PARENT**A. Policy**

A parent/caretaker who is applying for Medicaid for himself and on behalf of a child under age 18 (DCSE will not pursue medical support for children age 18 and over unless a court order has extended support beyond age 18) who has an absent parent must cooperate with the agency and DCSE in establishing the paternity and in obtaining medical support for the Medicaid eligible child, unless the:

- parent/caretaker is an MI pregnant woman and is requesting assistance for herself and her child born out of wedlock, or
- the parent/caretaker has good cause for not cooperating, or
- the parent/caretaker is only eligible under the Family Planning Services (FPS) covered group.

Explain and offer DCSE services to **all** Medicaid applicants, who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child's parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

If the parent/caretaker is required to cooperate with the agency in the pursuit of support from an absent parent as a condition of eligibility and refuses or fails to cooperate, he/she is ineligible for Medicaid. The parent's refusal or failure to cooperate does not affect the child's eligibility for Medicaid.

B. DCSE

DCSE District Offices were established in all regions and have the responsibility of pursuing support from absent legally responsible parent(s) and establishing paternity when the alleged father is absent from the home. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child (ren), and court action to secure support from the absent legally responsible parent. The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.

- C. Cooperation with DCSE** Medicaid *applicants and* recipients (except an MI pregnant woman under certain conditions in D. below, child-only cases in G. below, and FPS woman in H. below) are required to cooperate with paternity establishment and securing medical support as a condition of eligibility for Medicaid. Cooperation in the establishment or enforcement of a child support obligation is optional and Medicaid recipients may refuse these services not related to medical support or paternity establishment.
- D. Exception For MI Pregnant Women** An MI pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.
- E. No Exception For MN Pregnant Women** If a pregnant woman has countable income over the MI limit, she may be eligible for medically needy (MN) Medicaid if her resources are within the MN limit, she meets a spenddown and she meets all nonfinancial requirements including cooperation in pursuing support. An MN pregnant woman must cooperate with the agency in obtaining medical support for herself and any child for whom she applies from a legally responsible relative, unless she has good cause for not cooperating.
- F. Child Born to Medicaid Eligible Pregnant Woman** When a child is born to a Medicaid eligible woman and is enrolled in Medicaid, contact the parent with whom the child lives as soon as administratively possible, but no later than 60 days after the child's birth to explain and offer DCSE services.
- A child born to a Medicaid eligible pregnant woman remains eligible for Medicaid even when the parent/caretaker refuses to cooperate with DCSE in establishing paternity and pursuing support. The parent/caretaker's refusal to cooperate with DCSE results in the parent/caretaker's ineligibility for Medicaid, regardless of the covered group, but does not impact the child.
- G. Child-Only Cases** In child-only cases, cooperation with DCSE in the establishment of paternity and the pursuit of support is not a condition of the child's eligibility. DCSE services are available to all Medicaid recipients, but the parent/caretaker's refusal or failure to cooperate with DCSE will not affect the child's Medicaid eligibility.
- H. Family Planning Services (FPS) Covered Group** For the FPS covered group, cooperation with DCSE in the establishment of paternity and pursuit of support is not a condition of eligibility. The woman's refusal or failure to cooperate with DCSE does not affect her eligibility in this covered group (see M320.302).
- I. Procedures For Pursuing Support** The procedures for pursuing support from absent parents are different depending on whether or not the parent/caretaker is also a Medicaid applicant/recipient.

**1. Parent/
Caretaker is a
Medicaid
Applicant/
Recipient**

When the parent/caretaker is also applying for Medicaid and cooperation with DCSE is a condition of the eligibility, the cooperation requirements must be met or good cause for not cooperating must be established prior to approval. A parent/caretaker who does not meet the cooperation requirements and does not establish good cause for not meeting the cooperation requirements is not eligible for Medicaid.

The following forms are used to determine if the cooperation requirements are met.

**a. "The Notice of Cooperation and Good Cause", form #032-03-036
(see M0250, Appendix 1)**

The "Notice of Cooperation and Good Cause" form is used to inform all parent/caretakers who apply for Medicaid for children who have an absent parent of the benefits of cooperation, claiming good cause for not cooperating, the good cause determination, and penalty for refusing or failing to meet cooperation requirements. The "Notice of Cooperation and Good Cause" must be given to all parent/caretakers who apply for children who have an absent parent (AP). On the "Notice of Cooperation and Good Cause", the applicant/recipient can choose to:

- agree to cooperate with DCSE;
- claim good cause for not cooperating with DCSE ; or
in child only cases, refuse to cooperate with DCSE.

The parent/caretaker's choice determines whether additional forms must be completed.

b. Parent/Caretaker Agrees to Cooperate with DCSE

Complete the "Absent Parent/Paternity Information" form #032-03-501 (see M0250, Appendix 3) when the parent/caretaker agrees to cooperate with DCSE. The "Absent Parent/Paternity Information" form is used to provide information that will be beneficial to DCSE in locating the absent responsible person. This form is completed at initial application, when an individual is added to the family or budget unit, and/or at redetermination. *The 501 form must be returned before enrolling an eligible individual in Medicaid.*

For DCSE to have a "workable case," certain key information must be obtained when completing the form. Key information includes the AP's name, Social Security number, date of birth, current and past addresses, employers, and parent's name and address. When there is no legal parent or acknowledged father and more than one individual is named as a child's parent, refer all named individuals.

When support is received from the absent responsible parent who is married to someone other than the parent filing the Medicaid application and he has requested that his family not be involved, the address where the responsible parent wishes to be contacted should be noted. All future contacts with such absent responsible parent regarding support will be made by DCSE.

If voluntary or court-ordered third party payments such as rent are being made by the absent responsible parent, a notation of such payment must be made on the form.

The agency must complete page 4 of the form and send the completed document to the District DCSE office when the Medicaid application is approved. The full range of DCSE services will be provided to all referred cases unless DCSE is notified that the parent/caretaker elects partial services for the child.

c. Parent/Caretaker Claims Good Cause

The cooperation requirements can be waived when the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can legally assign rights. Good cause exists when the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.

Complete the "Good Cause Determination", #032-03-035 (see M0250, Appendix 2) when the parent/caretaker claims good cause for not cooperating with DCSE. The parent or legal custodian must provide evidence to support the claim to be excused from cooperating.

The local agency may determine that cooperation would be harmful to the child only if one or more of the following circumstances exist:

- anticipation that cooperation will result in physical or emotional harm to the child;
- anticipation that cooperation will result in physical or emotional harm to the parent which would impair the ability to care for the child;
- the child was conceived as a result of rape or incest;
- legal proceedings for the adoption of the child are pending;
or

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The parent or spouse offers a good cause beyond the parent's or spouse's control.
4. There was a failure to receive DMAS' request for information or notification for a reason not attributable to the parent or spouse. Lack of a forwarding address is attributable to the parent or spouse.
5. The required information on the group health plan could not be obtained from the employer.
6. The recipient demonstrates a medical need for a specific coverage provided by an available group health plan which does not meet the DMAS established cost-effectiveness criteria. This specific coverage is not provided by Medicaid or other group health plans which do meet the DMAS established cost-effectiveness criteria.

**F. Disenrollment
from a Group
Health Plan**

If an individual disenrolls from a group health plan which DMAS has determined to be cost-effective, or fails to pay the premium to maintain the group health plan, the individual loses eligibility for Medicaid. An Advance Notice of Proposed Action must be sent prior to canceling coverage.

**G. HIPP Application
Process**

Each applicant or recipient who reports that a member of his assistance unit is employed more than 30 hours each week and is eligible for coverage under an employer's group health plan must be given the HIPP Fact Sheet and *a HIPP Application Package containing the HIPP Application, the Medical History Questionnaire and the Insurance Verification Form*. The applicant must complete the HIPP Application and Medical History Questionnaire. The applicant or recipient must give the Insurance Verification Form to the employer. The employer is to return the Insurance Verification Form to the HIPP Unit at DMAS. *The HIPP Application Package is available on line at <http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/general/HIPP1.pdf>.*

If the applicant or recipient reports that the employer does not offer a group health plan or the individual is not eligible for coverage under the employer's group health plan, do not obtain the HIPP Application and Medical History Questionnaire or require the applicant/recipient to give the Insurance Verification Form to the employer.

**1. Copy
Insurance
Card**

If the applicant or recipient is already enrolled in the employer's group health plan, make a copy of the insurance card.

2. If Recipient Is Eligible, Send To HIPP Unit

If the applicant is determined to be eligible for Medicaid or the recipient is determined to remain eligible for Medicaid, complete the enrollment procedures in MMIS. Send the HIPP application, the Medical History Questionnaire, and the copy of the insurance card (if already enrolled in a group health plan) to the HIPP Unit, Department of Medical Assistance Services, Suite 1300, 600 E. Broad Street, Richmond, VA 23219.

Retain a copy of the HIPP application in the case record.

3. HIPP Unit Actions

The HIPP Unit will notify the recipient and DSS of the decision on cost-effectiveness of the group health plan and premium payment.

If the recipient is approved for HIPP payment of the group health plan premium and the recipient was not previously enrolled in the group health plan, the TPL information in MMIS will be updated by DMAS.

Payment will be made to the recipient for the employee's part of the insurance premium. **Payments to the recipient from the HIPP Program are not income to the assistance unit.**

H. Notice of Non-cooperation

The HIPP Unit will notify the agency if the recipient has not cooperated in enrolling in the cost-effective group health plan or paying the premiums to maintain enrollment in the group health plan. Upon receipt of this notification, if good cause for non-cooperation cannot be established, the agency must mail an "Advance Notice of Proposed Action" giving adequate notice of the cancellation of the non-cooperating individual's Medicaid coverage.

M0310.123 PARENT**A. Definition**

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

The presence in the home of a “substitute parent” or “man in the house” is not an acceptable basis for a finding of no deprivation. If a man not married to the mother is living in the home, he is the parent (the acknowledged father) when:

- the man has been found by a court to be the child’s father.
- the man has admitted paternity either before a court, or voluntarily in writing, under oath.
- the man’s name appears on the child’s birth certificate issued by the Virginia Department of Health Bureau of Vital Statistics.
- the child has been placed by a court with the man or a relative of the man on the basis that his is the child’s father.

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

B. Procedure

Section M0320.306 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

M0310.124 PREGNANT WOMAN**A. Definition**

A woman of any age who is medically determined to be pregnant meets the definition of a pregnant woman.

1. Effective Date

The pregnant woman definition is met the first day of the estimated month of conception as medically verified, or the first day of the earliest month which the medical practitioner certifies as being a month in which the woman was pregnant.

The definition of “pregnant woman” is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

Example #3: a pregnant woman applies for Medicaid in May 1997; she received medical treatment in March and April 1997. The physician gives her a written statement dated May 20, 1997 saying that he “treated her in March 1997. She was approximately 3 months pregnant at that time. She is still pregnant this date.” Therefore, her pregnancy is

medically verified for February - April 1997, since the doctor's statement verifies that she was pregnant in February, March, April, and May.

B. Procedures

1. Verification

Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner. Documentation of how the pregnancy was verified must be included in the case record.

If retroactive converge is requested the statement must also include an estimated month of conception since the pregnant woman definition is not met in any month prior to the conception month. If the medical practitioner cannot or will not give an estimated month of conception, the practitioner's certification that the woman was and is pregnant in the specific months for which Medicaid coverage is requested will suffice as pregnant woman definition verification.

Proof of the birth of a child to the mother is sufficient verification of the mother's pregnancy in the three months prior to the child's birth month.

2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Two of the Medicaid covered groups are specifically for pregnant women: MI Pregnant Women and MN Pregnant Women.

See section M0320.301 for the MI pregnant woman covered group requirements, and section M0330.301 for the MN pregnant woman covered group requirements.

M0310.125 QDWI

A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.209 for the procedures to use to determine if an individual meets the QDWI covered group.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

- 1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

The non-protected spouse's eligibility is evaluated in another covered group.

- 2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.
- 3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Cost-of-living calculation formula:

- $$\begin{aligned}
 a. \quad & \frac{\text{Current Title II Benefit}}{1.041 \text{ (1/06 Increase)}} = \text{Benefit Before 1/06 COLA} \\
 b. \quad & \frac{\text{Benefit Before 1/06 COLA}}{1.027 \text{ (1/05 Increase)}} = \text{Benefit Before 1/05 COLA} \\
 c. \quad & \frac{\text{Benefit Before 1/05 COLA}}{1.021 \text{ (1/04 Increase)}} = \text{Benefit Before 1/04 COLA} \\
 d. \quad & \frac{\text{Benefit Before 1/04 COLA}}{1.014 \text{ (1/03 Increase)}} = \text{Benefit Before 1/03 COLA} \\
 e. \quad & \frac{\text{Benefit Before 1/03 COLA}}{1.026 \text{ (1/02 Increase)}} = \text{Benefit Before 1/02 COLA}
 \end{aligned}$$

Contact a Medical Assistance Program Specialist for amounts for years prior to 2002.

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-06 \$88.50
 1-1-05 \$78.20
 1-1-04 \$66.60
 1-1-03 \$58.70
 1-1-02 \$54.00

b. Medicare Part A premium amounts:

1-1-06 \$393.00
 1-1-05 \$375.00
 1-1-04 \$343.00
 1-1-03 \$316.00
 1-1-02 \$319.00

Contact a Medical Assistance Program Specialist for amounts for years prior to 2002.

6. Classification

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. *Aid category (AC)* is "053".

**3. SLMB's AC
Changes To
Full Coverage
AC**

When an enrolled SLMB becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:

- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "024";
- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

**4. Spenddown
Status**

At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

**4. SLMB
Meets
Spenddown**

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstatement the recipient's coverage with the begin date as the first date the spenddown was met, *and enter the end date of the spenddown period*. AC is medically needy NOT dual-eligible:

- 018 for an aged MN individual NOT eligible as QMB;
- 038 for a blind MN individual NOT eligible as QMB;
- 058 for a disabled MN individual NOT eligible as QMB.

**6. Spenddown
Period Ends**

After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.

The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

**7. SLMB
Enters
Long-term
Care**

The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "024". Reinstatement the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.208 QUALIFIED INDIVIDUALS-(QI)**A. Policy**

P.L. 105-33 (Balanced Budget Act of 1997) – mandated Medicaid coverage of Qualified Individuals who would be Qualified Medicare Beneficiaries (QMBs) except that their income exceeds the QMB income limit. When implemented on January 1, 1998, the QI covered group consisted of two components, Group 1 and Group 2. Group 1 individuals receive Medicaid coverage for the payment of their Medicaid Part B premium. Group 2 individuals receive Medicaid coverage for the portion of the Medicare Part B premium that is attributable to the cost of transferring coverage of home health services to Medicare Part B from Part A. The federal authority for Group 2 expired and Medicaid coverage for this component ended December 31, 2002. Effective January 1, 2003, the QI covered group consists only of the component formerly referred to as "Group 1".

Like QMBs and SLMBs, eligible QIs are also placed on a medically needy spenddown if resources are within the medically needy limit.

**1. Not An
Entitlement**

Medicaid coverage for this covered group is not an individual entitlement, which means that when the Department of Medical Assistance Services (DMAS) runs out of money for this covered group, no additional eligible individuals in this covered group will receive Medicaid benefits. DMAS will notify the DSS Central Office when the money for this covered group will run out.

Local departments of social services must continue to take and process applications for this covered group even after the funds run out. The MMIS will generate and send a notice to the recipient if the recipient will not receive the benefit because the funds have run out.

Applications for QI coverage for an upcoming year may not be taken until January 1 of that year.

D. QI Coverage Period

If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, **and ends December 31 of the calendar year**, if funds are still available for this covered group. *Applications for QI coverage for an upcoming year may not be taken until January 1 of that year, and coverage under this group cannot begin earlier than January 1 of the calendar year.* The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

E. Covered Service

The eligible QI will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The QI will not receive a Medicaid card.**

F. Enrollment**1. Aid Category**

QI = 056

2. Begin and End Dates

The begin date of coverage cannot be any earlier than January 1 of the calendar year.

Do not enter an end date of coverage. The VaMMIS will automatically cancel the recipient's coverage on December cut-off, effective December 31 of the calendar year.

3. Recipient's Covered Group Changes To QI**a. Before November Cut-off**

An enrolled recipient's *AC* cannot be changed to "056" using a "change" transaction in the VaMMIS. If, **before November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate *AC*.

b. After November Cut-off

If, **after November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient's Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient's full coverage effective December 31, using cancel reason "07".

**G. MMIS
Procedures For
QI Recipients**

The MMIS computer will

- automatically cancel the QI recipient's coverage effective December 31 of each calendar year, and
- send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.

D. Entitlement and Enrollment

Eligibility in the FPS covered group can extend no longer than the 24th month following the end of the pregnancy.

The eligibility worker must cancel the MI Pregnant Women enrollment effective the last day of the month of the 60-day postpartum period and enroll the woman in FPS the first day of the following month. An eligibility determination is not required for those MI Pregnant Women whose pregnancy ends on or after October 1, 2003.

Women who were not enrolled in the MI Pregnant Women covered group who had a Medicaid covered pregnancy-related service must have an eligibility determination. If the woman does not meet a covered group entitled to full Medicaid benefits, but meets the requirements of the FPS covered group, she is to be enrolled in FPS.

The AC for FPS is "080".

Written notice must be sent to inform the recipient of her eligibility in the FPS covered group and of the reduction in coverage. She must also be advised of the opportunity to receive a redetermination of eligibility for full coverage.

The eligibility worker must *enter the actual date of the child's birth, or the actual date the pregnancy terminated, in the Expected Delivery Date field on the recipient's demographics screen* in MMIS. MMIS will automatically send the advance notice and cancel FPS coverage 24 months after the pregnancy ends.

The MMIS will cancel this coverage using reason code "036".

M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)**A. Policy**

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits. Virginia has elected to cover children between the ages of 6 and 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

C. Financial Eligibility

- 1. Assistance Unit** Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.
- 2. Asset Transfer** The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.
- 3. Resources** There is no resource limit.
- 4. Income** The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.
- 5. Income Changes** Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.
- 6. Income Exceeds MI Limit** A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

2006: \$904 - \$603 = \$301

2005: \$869 - 579 = \$290

Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = *\$603 for 2006*
\$579 for 2005

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = *\$904 for 2006*
\$869 for 2005

Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

2006: \$904 - \$603 = \$301

2005: \$869 - 579 = \$290

GENERAL**M0810.001 INCOME AND ELIGIBILITY****A. Introduction**

The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles**1. Who is Eligible**

An individual is eligible for Medicaid if the person:

- meets a *covered group*; and
- meets the nonfinancial requirements; and
- meets the *covered group's* resource limits; and
- meets the *covered group's* income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS**A. Income Limits**

The Medicaid *covered group* determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy *covered group*.

2. Categorically Needy Non-Money Payment-Protected Cases Only

<ul style="list-style-type: none"> • Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits 		
Family Unit Size	2006 Monthly Amount	2005 Monthly Amount
1	\$603	\$579
2	904	869
<ul style="list-style-type: none"> • For individual or couple whose total food and shelter needs are contributed to him or them 		
Family Unit Size	2006 Monthly Amount	2005 Monthly Amount
1	\$402	\$386
2	602.67	579.34

**3. Categorically
Needy-Non
Money Payment
(CNNMP) -
300% of SSI**

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as “what is not income” in S0815.000.

<ul style="list-style-type: none"> Categorically Needy-Non Money Payment 300% of SSI 		
Family Size Unit 1	2006 Monthly Amount \$1,809	2005 Monthly Amount \$1,737

**4. Medically
Needy**

a. Group I		
Family Unit Size 1	Semi-annual \$ 1,447.52	Monthly \$ 241.25
2	1,843.37	307.22
b. Group II		
Family Unit Size 1	Semi-annual \$ 1,670.22	Monthly \$ 278.37
2	2,056.98	342.83
c. Group III		
Family Unit Size 1	Semi-annual \$ 2,171.28	Monthly \$ 361.88
2	2,618.02	436.33

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
2/18/05; and
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 4/01/05**

ABD 80% FPL 1	Annual \$ 7,656	Monthly \$638
2	10,264	856
QMB 100% FPL 1	Annual \$ 9,570	Monthly \$ 798
2	12,830	1,070
SLMB 120% of FPL 1	Annual \$ 11,484	Monthly \$ 957
2	15,396	1,283
QI 135% FPL 1	Annual \$12,920	Monthly \$1,077
2	17,321	1,444
QDWI 200% of FPL 1	Annual \$19,140	Monthly \$1,595
2	25,660	2,139

C. Procedure

- 1. Verification**
 - a. Verify these payments by examining documents in the individual's possession which reflect:
 - the amount of the payment,
 - the date(s) received, and
 - the frequency of payment, if appropriate.
 - b. If the individual has no such evidence in his possession, contact the source of the payment.
 - c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.
- 2. Assumption**

Assume that any honoraria received is **in consideration of services rendered**, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honoraria is for something other than services rendered (e.g., travel expenses or lodging).
- 3. Expenses of Obtaining Income**

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)
- 4. Documentation**

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

- D. References**
- Royalties as unearned income, S0830.510.
 - To determine deductible IRWE/BWE, see S0820.535 - .565.

EARNED INCOME EXCLUSIONS

S0820.500 GENERAL

A. Policy

- 1. General**

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.
- 2. Other Federal Laws**

First, income is excluded as authorized by other Federal laws.

3. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

- a. Federal earned income tax credit payments
- b. Up to \$10 of earned income in a month if it is infrequent or irregular
- c. *For 2005, up to \$1,410 per month, but not more than \$5,670 in a calendar year, of the earned income of a blind or disabled student child.*

For 2006, up to \$1,460 per month, but not more than \$5,910 in a calendar year, of the earned income of a blind or disabled student child.
- d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month
- e. \$65 of earned income in a month
- f. Earned income of disabled individuals used to pay impairment-related work expenses
- g. One-half of remaining earned income in a month
- h. Earned income of blind individuals used to meet work expenses
- i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

5. Couples

The \$20 general and \$65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 \$20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

- 1. General**

For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
In calendar years before 2001	\$ 400	\$1,620
In calendar year 2001	\$1,290	\$5,200
In calendar year 2002	\$1,320	\$5,340
In calendar year 2003	\$1,340	\$5,410
In calendar year 2004	\$1,370	\$5,520
In calendar year 2005	\$1,410	\$5,670
<i>In calendar year 2006</i>	<i>\$1,460</i>	<i>\$5,910</i>
- 2. Qualifying for the Exclusion**

The individual must be:

 - a child under age 22; and
 - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility**

Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases**

The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

- 1. Application of the Exclusion**

Apply the exclusion:

 - consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
 - only to a student child's own income.
- 2. School Attendance and Earnings**

Develop the following factors and record them:

 - whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
 - the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be \$65 or less per month.

C. References

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

D. Example
*(Using April
2002 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns \$1,600 a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns \$800 a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August
\$1600.00 gross earnings
- 1320.00 student child exclusion
\$ 280.00
- 20.00 general income exclusion
\$ 260.00
- 65.00 earned income exclusion
\$ 195.00
- 97.50 one-half remainder
\$ 97.50 countable income

Jim has used up \$3,960 of his \$5,340 yearly student child earned income exclusion (\$1,320 in each of the three months).

September
\$800.00 gross earnings
- 800.00 student child exclusion
0 countable income

Jim has now used up \$4,760 of his \$5,340 yearly student child earned income exclusion.

October
\$800.00 gross earnings
- 580.00 student child exclusion *remaining (\$5,340-\$4,760=\$580)*
\$220.00
- 20.00 general income exclusion
\$200.00
- 65.00 earned income exclusion
\$135.00
- 67.50 one-half remainder
\$ 67.50 countable income

Jim has exhausted his entire \$5,340 yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

M0830.420 SUPPORT PAYMENTS (CHILD SUPPORT, SPOUSAL SUPPORT, ALIMONY) --GENERAL

A. Policy

1. **Definitions**

Alimony and support payments are cash. In-kind contributions for food, clothing or shelter are not income. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called "maintenance") is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.
2. **Alimony, Spousal, and Other Adult Support**

Alimony, spousal, and other adult support payments are unearned income.
3. **Child Support Exclusion**

Child support payments are unearned income *to the child*. One-third of the amount of a payment made to or for an eligible child by an absent parent is *excluded*. (See B. below for definition of an absent parent for purposes of this exclusion.)
4. **Child Support on Behalf of an Adult Child**
 - a. **Current Child Support Received on Behalf of an Adult Child**

Child support payments (excluding arrearages) received for an adult child by a parent after an adult child stops meeting the definition of a child are income to the adult child. The support payments are income to the adult child whether or not the adult child lives with the parent or receives any of the child support payment from the parent. Such support payments are not subject to the one-third exclusion.
 - b. **Child Support Arrearages Received on Behalf of an Adult Child**

When a parent receives a child support arrearage payment on behalf of an adult child:

 - *Any amount of that payment that the parent receives and does not give to the adult child is income to the parent. The portion of the arrearage payment retained by the parent is not income to the adult child and does not affect the adult child's Medicaid eligibility.*
 - *Any amount of that payment that the parent gives to the adult child is income to the adult child in the month given, not income to the parent.*
 - *The one-third child support exclusion does not apply.*
 - *When an adult child receives a child support arrearage payment directly from the absent parent, the arrearage payment is income to the adult child.*

B. Definition--Absent Parent

1. General

A parent is considered absent if the parent and the child do not reside in the same household. **NOTE:** There is no connection between the terms used in this subsection and the concept of "temporary absence" for deeming purposes.

- a. If the periods of living together are brief and the child remains independent or under the care and control of another person, agency, institution, or is living in the home of another, the parent is usually considered absent unless he/she retains **parental responsibility and control**.
- b. A parent is not considered absent if he is away due to **employment** (except for military service), intends to resume living with the child, and retains parental control and responsibility.
- c. A child (or parent) who is a **boarding student** in an educational facility is not considered absent.

C. Procedure

1. Verification of Amount and Frequency

To verify the amount and frequency of support payments use:

court records;
records of an agency through which the payments are made;
documents in the individual's possession; or
contact with the source of the payment.

If this is not successful, accept the individual's notarized statement.

2. Relationship

Accept the individual's allegation of relationship of the payer to the payee unless you doubt the allegation.

3. One Payment for Two or More Individuals

In the case of one payment for two or more individuals:

- a. To determine one individual's share of a support payment made for more than one person, **look first to the legal document** setting the payments.
- b. **If the legal document** addresses each person's share, divide the payment according to the terms of the document. If the payment does not equal the established support amount, contact the source of the payment to establish intent and divide the payment according to that intent. If this is unsuccessful, divide the payment proportionately.
- c. If **no legal document** exists or the document does not address shares, contact the source of the payment to establish intent and allocate the support according to that intent.
- d. If this is not successful, accept the individual's **signed allegation** of who the support is for and how the support is divided. If the individual does not know how the support should be divided, divide the payment equally.

D. References

Estimating income, S0810.600-.610

S0830.425 *RESERVED*

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2. Trusts Greater Than \$25,000

Trust(s) Greater than \$25,000 created after July 1, 1993 and before August 11, 1993

A single trust or multiple trust created after July 1, 1993 and before August 11, 1993, when the corpus or corpora is more than \$25,000, may have partial exclusion of the corpus.

D. Development/Documentation

1. Verify Trust(s)

- **Obtain copy of trust(s) document(s).**
- Verify **current value of the** corpus or corpora of the trust(s).

2. Apply Disregard

- a. Prorate \$25,000 by the number of trusts**
- b. Subtract prorated amount from corpus or corpora of the trust(s).**

3. Countable Resource

The remainder of the corpus or corpora of the trust(s)

- that may be paid under the terms of the trust
- without any limits imposed by **any** void restrictive clause
- is counted as an available resource to the applicant or recipient regardless
- of whether or not:
- the trust is irrevocable; or
- the trust was established for purposes other than to make the individual eligible for Medicaid; or
- the trustee exercises his discretion to distribute trust payments to the applicant/recipient.

E. References

Trusts Created After July 1, 1993 and Before August 11, 1993 with Corpus in Excess of \$25,000, M1140.403.

RETAINED CASH AND IN-KIND PAYMENTS

S1130.600 RETROACTIVE SSI AND SS PAYMENTS

A. Definitions

- 1. Retroactive SSI Benefits**

Retroactive SSI benefits -- which include any federally administered State supplementation -- are SSI benefits issued in any month after the calendar month for which they are paid. Thus, benefits for January that are issued in February are retroactive.
- 2. Retroactive SS Benefits**

Retroactive SS benefits are those issued in any month that is more than a month after the calendar month for which they are paid. *Therefore, SS benefits for January that are issued in February are not retroactive, but SS benefits for January that are issued in March are retroactive.*

B. Policy Principles

- 1. 9-Month Exclusion**

The unspent portion of retroactive SSI and SS benefits received on or after 11/01/05 is excluded from resources for the nine (9) calendar months following the month in which the individual receives the benefits.
- 2. 6-Month Exclusion**

The unspent portion of retroactive SSI and SS benefits *received before 11/01/05* is excluded from resources for the six (6) calendar months following the month in which the individual receives the benefits.

C. Related Policies

- 1. Interest**

Interest earned by funds excluded under this provision is not excluded from income under this provision. Develop interest per S0830.500.
- 2. Commingled Funds**

See S1130.700 if excluded funds have been commingled with other funds.

3. Value
 - a. Series E, EE, and I paper bonds
 - **On-line Verification** at:
<http://www.publicdebt.treas.gov/sav/savcalc.htm>
 - Current copy of the Table of Redemption Values for US Savings Bonds
 - **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.
 - b. Series E, EE, and I electronic bonds
 - Ask individual to obtain his "Current Holdings" list from the Treasury web site at: <http://www.savingsbonds.gov/>
 - Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.
 - c. **Series H and HH Bond After Maturity**
After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.
4. Photocopy Document the file with a photocopy or certification of the bond(s). See S1140.010 C. on photocopying U.S. Government obligations.
5. Follow-up, if Appropriate If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

A. Introduction

1. **Bond** A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.
2. **Municipal Bond** A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).
3. **Corporate Bond** A corporate bond is the obligation of a private corporation.
4. **Government Bond** A government bond, as distinct from a U.S. Savings Bond (see S1140.240), is a **transferable** obligation issued or backed by the Federal Government.

- B. Operating Policy** Municipal corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

- C. Development and Documentation** Development and documentation instructions for stocks (S1140.220) also apply to bonds.

M1140.260 ANNUITIES (Effective for All Applications Received On or After December 1, 2004)

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

B. Operating Policy

1. An annuity containing a balloon payment is considered an available resource, and the value of the annuity is counted.
2. An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable.
3. A non-employment related annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity (a) is irrevocable; (b) pays out principal and interest in equal monthly installments (no balloon payment) to the individual over a total number of months that is less than or equal to the actuarial life expectancy of the annuitant; (c) names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity not to exceed the amount of any Medicaid funds expended on *long-term care* for the individual during his lifetime; and (d) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth of Virginia cannot exceed the total amount of funds for long-term care services expended on behalf of the individual.
4. Annuities issued prior to 12-01-04 which do not: (a) provide for the payout of principal and interest in equal monthly installments and (b) for which documentation is received from the issuing company that the payout arrangements cannot be changed will be considered to meet the above requirements once amended to name the Commonwealth of Virginia as the primary beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended on the individual during his lifetime.
5. Have the individual submit documentation showing ownership of an annuity. If the owner is the Medicaid applicant or the applicant's spouse, the value of the annuity is a countable resource unless it meets the criteria listed in B.3 above.

5. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

6. Day Support Waiver for Individuals with Mental Retardation

The Day Support Waiver for Individuals with Mental Retardation (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the MR Waiver are considered for DS Waiver services. Individuals may remain on the MR Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services

Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or mental retardation, and who are age 55 or older. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement.

Individuals in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- *assistance with activities of daily living*
- *medication administration by licensed professionals*
- *nursing services for assessments and evaluations*
- *therapeutic social and recreational programming which provides daily activities for individuals with dementia.*

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

- A. Introduction** An individual in LTC must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:
- B. Asset Transfer** The asset transfer policy is found in subchapter M1450.
- C. Resources** The resource eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.
- The resource eligibility requirements for married individuals in LTC who have community spouses are found in subchapter M1480 of this chapter.
- D. Income** The income eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.
- The income eligibility policy for individuals in LTC who have community spouses is found in subchapter M1480.

M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

- A. Introduction** Medicaid-eligible individuals must pay a portion of their income to the LTC provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called “patient pay.”
- B. Patient Pay** The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

- A. Introduction** The general application requirements applicable to all Medicaid applicants/recipients found in chapter M01 also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Community-Based Care (CBC) applicants apply in their locality of residence.

ABD patients in state *Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS)* facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state *DMHMRSAS* facilities. When an enrolled ABD Medicaid recipient is admitted to a state *DMHMRSAS* facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.600 for case transfer policy.

C. Who Can Apply

The individual, his/her authorized representative (person authorized to conduct business for the applicant) can file the application for Medicaid and make the assignment of rights and the declaration of citizenship.

M1410.300 NOTICE REQUIREMENTS

A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The DMAS-122 form is the formal notice to the LTC provider of the recipient's eligibility for Medicaid and for Medicaid payment of LTC services.

The notice requirements found in this section are used for all LTC cases.

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The DMAS-122 is not completed for individuals in the AAL Waiver. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

B. Forms to Use

1. Notice of Action on Medicaid (#032-03-008)

The EW must send the Notice of Action on Medicaid to the applicant/recipient and the person who is authorized to conduct business for the Applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

Appendix 2 to this subchapter contains a copy of the Notice of Action on Medicaid.

**2. Notice of
Obligation for
Long-Term Care
Costs
(#032-03-062)**

The Notice of Obligation for Long-term Care Costs is sent to the applicant/recipient and the person managing the applicant's affairs to notify them of the amount of patient payment responsibility.

The "Agency" copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider. **Failure to return a signed form has no impact on the individual's eligibility status.** Processing of the application shall not be delayed pending the return of the signed form. This form is an agreement only.

Appendix 3 to this subchapter contains a copy of the Notice of Obligation for Long-Term Care Costs.

**3. Patient
Information
DMAS-122**

The Patient Information form DMAS-122:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- provides the monthly amount an eligible patient must pay to the provider toward the cost of care;
- reflects changes in the patient's level of care;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

a. When to Complete the DMAS-122

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage. The EW must update the DMAS-122 and send it to the provider or case manager whenever the patient pay changes.

The EW must update the DMAS-122 and send it to the provider or case manager at least every 12 months even if the patient pay does not change. A currently dated DMAS-122 must be completed and sent to the provider or case manager when the annual redetermination is completed, if a DMAS-122 form was not sent to the provider or case manager within the past 12 months.

b. Where to Send the DMAS-122

1) Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

2) Medicaid CBC Waiver Patients

- a) For MR *or* DS Waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.
- b) For Technology-Assisted Individuals Waiver recipients, send the DMAS-122 to:

DMAS Case Manager
Technology Assisted Waiver Program
DMAS
600 E. Broad Street
Richmond, VA 23219

- c) For EDCD Waiver recipients who have chosen consumer-directed services, send the DMAS-122 to the Service Facilitator. For all other EDCD waiver recipients, follow the instructions in e) below.
- d) For DD Waiver recipients, send the DMAS-122 to the Support Coordinator.
- e) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services send the DMAS-122 to the personal care services provider or adult day health provider. If the patient receives both personal care and adult day health care, send the DMAS-122 to the personal care provider.
- f) Except for Technology- Assisted Waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Waiver Unit **only upon request** from that unit. Upon request from the CBC Waiver Unit, send a copy of the DMAS-122 to the unit at the following address:

CBC Waiver Unit
DMAS
600 E. Broad Street
Richmond, VA 23219

Appendix 4 to this subchapter contains a copy of the DMAS-122 form and instructions.

**4. Advance
Notices of
Proposed
Adverse
Action**

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action (#032-03-018) Appendix 1

The Advance Notice of Proposed Action must be used for an adverse eligibility action when:

- eligibility for Medicaid will be canceled,
- eligibility for full-coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage,
- Medicaid payment for LTC services will be terminated because of asset transfer.

**b. Advance Notice of Obligation for Long-Term Care Costs
(#032-03-062) Appendix 3**

An increase in the patient pay amount is an adverse action. Send the “Notice of Obligation for Long-term Care Costs” as the advanced notice to the applicant/recipient and the person managing the applicant's affairs to notify them at least 10 days in advance of an increase in the patient pay responsibility. **Do not send the “Advance Notice of Proposed Action” when patient pay increases.**

The “Agency” copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider. **Failure to return a signed form has no impact on the individual's eligibility status.**

**5. Medicaid
Redetermina-
tion For Long-
term Care
(#032-03-369)**

The “Medicaid Redetermination for Long-term Care” form #032-03-369, is the form used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

Appendix 5 contains a copy of the form.

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- Peninsula AIDS Foundation
- Northern Virginia AIDS Project
- INOVA System/Office of HIV
- Council of Community Services
- AIDS Support Group, Inc.
- Whitman Walker Clinic of Northern Virginia

5. Individual and Family Developmental Disabilities Support (DD)

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.

6. *Alzheimer's Assisted Living (AAL) Waiver*

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

7. *Day Support Waiver for Individuals with Mental Retardation (DS) Waiver*

Local CSB and DMHMRSAS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DMHMRSAS staff.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure the eligibility determination process takes place simultaneously with screening decisions so that nursing facility placement or receipt of CBC services may be arranged as quickly as possible, prompt communication between screeners and eligibility staff must occur.

Each agency shall designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff, and DRS staff shall be given instructions on how to contact that person.

B. Procedures

1. Screeners

Screeners must inform the agency eligibility worker that the screening process has been initiated.

2. EW Action

The eligibility worker must begin to process the individual's Medicaid application when informed that the screening process has begun.

3. Provider Involvement

If the individual is found eligible and verbal assurance of approval by the screening committee has been received, the EW must provide, without delay, the facility or CBC provider with the recipient's Medicaid ID number.

4. Designated DSS Contact

The local DSS agency should designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital

social services staff and DRS staff should be given the name of, and instructions on how to contact, that person. This will facilitate timely communication between screeners and the eligibility determination staff.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes a local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals and verifies qualification for special personal maintenance allowances for temporary stays in long-term care facilities. The screening certification is valid for one year.

B. Procedures

1. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application or has been a patient in a nursing facility for at least 30 consecutive days;
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the EDCD or AIDS waiver;
- the individual leaves a nursing facility and begins receiving EDCD or AIDS waiver services; or
- the individual enters a nursing facility from out-of-state.

2. Documentation

a. If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record.

b. Substantiation is by:

- a DMAS-96 (see Appendix 1);
- a MR Waiver Level of Care Eligibility Form (see Appendix 2);
- a DD Waiver Level of Care Eligibility Form (see Appendix 3); or
- a *DS Waiver Level of Care Eligibility Form (see Appendix 4).*

c. The screening certification is valid for one year.

3. DMAS-96

For an individual who has been screened and approved for the EDCD, Technology-Assisted, or AIDS waiver, the DMAS-96 "Medicaid Funded Long-term Care Pre-admission Screening Authorization" form will be signed and dated by the screener. The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under "Nursing Home Pre-admission Screening." These numbers denote approval of Medicaid payment for a waiver service. See Appendix 1 for a copy of the DMAS-96.

- 4. EDCD Waiver Authorization for Consumer-Directed Services**

When an individual has been screened and approved for the EDCD waiver, the local DSS must determine his eligibility as an institutionalized individual and if eligible, enroll him in Medicaid. DMAS or its contractor must give final authorization for consumer-directed services. If the services are not authorized, the Service Facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.
- 5. MR Waiver Level of Care Eligibility Form**

For an individual who has been screened and approved for the MR waiver, the "MR Waiver Level of Care Eligibility Form" will be signed and dated by the DMHMRSAS representative. The "MR Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 2 for a copy of the "MR Waiver Level of Care Eligibility Form."
- 6. DS Waiver Level of Care Eligibility Form**

For an individual who has been screened and approved for the DS waiver, the "DS Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by the DMHMRSAS representative. The "DS Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 4 for a copy of the "DS Waiver Level of Care Eligibility Form."
- 7. DD Waiver Level of Care Eligibility Form**

For an individual who has been screened and approved for the DD waiver, a "DD Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services. See Appendix 3 for a copy of the "DD Waiver Level of Care Eligibility Form."
- 8. LTC Authorization Not Received**

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to establish the Medicaid pre-authorization. The date of receipt of such assurance and the name of the person providing the information must be entered in the case record.

If a pre-admission screening is required and the documented or verbal assurance of screening and approval is not received, Medicaid eligibility for an individual who is living in the community must be determined as a community resident using the rules applicable to a non-institutionalized Medicaid applicant.
- 9. LTC Authorization Rescinded**

The authorization for Medicaid-funded long-term care may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the level of care criteria for Medicaid-funded long-term care.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate his/her eligibility as a non-institutionalized individual.

Continue to use the institutional eligibility criteria for persons who are in a medical institution even though they no longer meet the level of care criteria. If eligible, Medicaid will not make a payment to the facility for the care.



COMMONWEALTH of VIRGINIA

*Department of
Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797*

DS Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____

Date: _____

Phone: _____

Confidentiality Statement: This document contains confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.

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Screenings can be completed by:

- Local and hospital screening committees
- AIDS services organizations (ASOs) contracted with DMAS

M1440.104 TECHNOLOGY-ASSISTED INDIVIDUALS WAIVER

A. General Description

"Technology-Assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community.

B. Targeted Population

Individuals who need both 1) a medical device to compensate for the loss of a vital body function and 2) substantial and ongoing skilled nursing care.

C. Eligibility Rules

The individual must meet the following basic requirements:

1. has a live-in primary care giver who accepts responsibility for the individual's health and welfare.
2. is not receiving services in a general acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.
3. is not residing in a board and care facility or adult care residence.
4. All patients under the waiver must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical facility.
5. Financial eligibility rules that apply to institutionalized individuals apply to patients under this waiver. Resource and income rules apply to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

The services provided under this waiver include:

- private duty nursing
- respite care

- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

E. Assessment and Service Authorization

The initial assessment and development of the plan of care is conducted by DMAS staff.

The following entities are authorized to screen for the Technology-Assisted Individuals Waiver:

- DMAS Health Care Coordinator.

M1440.105 DAY SUPPORT WAIVER

A. General Description

The Day Support (DS) Waiver is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may reside in an ICF/MR or may be in the community at the time of the assessment for DS Waiver services.

B. Targeted Population

Only those individuals on the urgent and non-urgent waiting lists for the MR Waiver are considered for DS Waiver services. Individuals may remain on the MR Waiver waiting list while receiving DS Waiver Services.

C. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

D. Services Available

Services available under the DS Waiver include:

- day support
- prevocational services

E. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB or DMHMRSAS case manager after completion of a comprehensive assessment. All recommendations are submitted to DMHMRSAS staff for final authorization.

M1440.106 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description *The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.***

The AAL waiver serves persons who are:

- *Auxiliary Grants (AG) recipients,*
- *have a diagnosis of Alzheimer's or a related dementia and no diagnosis of mental illness or mental retardation, and*
- *age 55 or older.*

B. Eligibility Rules *Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The DMAS-122 is not completed for individuals in the AAL Waiver.*

The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

C. Services Available *Services available under the AAL waiver are:*

- *assistance with activities of daily living*
- *medication administration by licensed professionals*
- *nursing services for assessments and evaluations*
- *therapeutic social and recreational programming which provides daily activities for individuals with dementia.*

D. Assessment and Service Authorization *Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.*

M1440.107 INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER (DD WAIVER)

- A. General Description**
- The Individual and Family Developmental Disabilities Support Waiver (DD waiver) provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of mental retardation. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution. This waiver serves persons who:
- have a diagnosis of developmental disability attributable to cerebral palsy, epilepsy or autism, or
 - any condition other than mental illness, found to be closely related to mental retardation.
- The developmental disability must have been manifested prior to the individual reaching age 22 and must be likely to continue indefinitely.
- B. Eligibility Rules**
- All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.
- The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.
- C. Services Available**
- Services available under the DD waiver are:
- support coordination (case management)
 - adult companion services
 - assistive technology
 - crisis intervention/stabilization
 - environmental modifications
 - residential support
 - skilled nursing
 - supported employment
 - therapeutic consultation
 - respite care
 - personal attendant services
 - consumer-directed personal and respite care.

- D. Assessment and Service Authorization** The initial assessment and development of the plan is conducted by qualified individuals under contract with DMAS. DMAS staff will review the contractor's plan and authorization.

M1440.200 COVERED SERVICES

- A. Introduction** This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.
- B. Waiver Services Information** Information about the services available under a waiver is contained in the following sections:
- M1440.201 Personal Care/Respite Care Services
 - M1440.202 Adult Day Health Services
 - M1440.203 Case Management Services
 - M1440.204 Private Duty Nursing Services
 - M1440.205 Nutritional Supplements
 - M1440.206 Environmental Modifications
 - M1440.207 Residential Support Services
 - M1440.208 Personal Assistance Services
 - M1440.209 Assistive Technology Services
 - M1440.210 Day Support Services
 - M1440.211 Supported Employment Services
 - M1440.212 Therapeutic Consultation Services
 - M1440.213 Personal Emergency Response System (PERS)
 - *M1440.214 Prevocational Services*

M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

- A. What Are Personal Care Services** Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.

- B. What are Respite Care Services** Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.
- C. Relationship to Other Services** An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.
- When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.
- D. Who May Receive the Service** An individual must meet the criteria of the EDCD Waiver, the AIDS Waiver, the Technology-Assisted Waiver or the MR Waiver in order to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

- A. What Is Adult Day Health Care** Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.
- B. Relationship to Other Services** ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.
- C. Who May Receive the Service** An individual must meet the *EDCD* Waiver criteria to qualify for ADHC services.

M1440.203 CASE MANAGEMENT SERVICES

- A. What is Case Management** Case Management services enable the continuous assessment, coordination and monitoring of the needs of the person that is HIV positive and symptomatic, or who has AIDS. Case Management services are viewed as an indirect service which enables the efficient and effective delivery of the other direct services included in the waiver. A patient may receive between 0 and 10 hours of Case Management services monthly.

These services may be provided in residential and/or non-residential settings to enable the individual to maintain the health status and functional skills necessary to live in the community and/or participate in community activities.

- B. Who May Receive the Service** Personal Assistance services cannot be offered to an individual who receives Assisted Living services in an Adult Care Residence. Personal Assistance services are available only to patients who are eligible under the MR waiver.

M1440.209 ASSISTIVE TECHNOLOGY SERVICES

- A. What is Assistive Technology** Assistive Technology (AT) is any device or environmental modification that increases the independence, safety or comfort of an individual.
- AT ranges from simple devices such as a jar opener or eyeglasses to complex devices such as a voice synthesizer or a powered wheelchair.
- B. Relationship to Other Services** This service is available only to persons who are receiving at least one other waiver service along with Case Management.
- C. Who May Receive the Service** This service is provided only to recipients of the MR Waiver.
- This service may be provided in residential and/or non-residential settings.

M1440.210 DAY SUPPORT SERVICES

- A. What is Day Support** Day Support services are provided primarily in non-residential settings, separate from the home or other community residence, to enable a person to acquire, improve, and maintain maximum functional abilities. This service includes a variety of training, support, and supervision. Prevocational training for patients who previously resided in a Medicaid-certified facility is included under this service.
- B. Relationship to Other Services** This service is available only to persons who are receiving at least one other waiver service along with Case Management.
- C. Who May Receive the Service** This service is available only to recipients of the DS and MR waivers.

M1440.211 SUPPORTED EMPLOYMENT SERVICES

- A. What is Supported Employment** Supported Employment is paid employment for persons with mental retardation for whom competitive employment at or above minimum wage is unlikely and who, because of the disability, need intensive ongoing

support, including supervision, training and transportation to perform in a work setting. Supported employment is conducted in a variety of community work sites where non-disabled persons are employed.

- B. Relationship to Other Services** This service is available only to recipients who are receiving at least one other waiver service along with Case Management.
- C. Who May Receive the Service** Supported Employment services are available only to recipients in the MR waiver.

M1440.212 THERAPEUTIC CONSULTATION SERVICES

- A. What is Therapeutic Consultation** Therapeutic Consultation is consultation and technical assistance provided by members of psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy or physical therapy professions to the individual, parent/family members, and Mental Retardation Waiver service providers. These consultation services help the individual and his/her caregiver(s) to implement his/her individual plan of care.
- B. Relationship to Other Services** Behavioral Analysis may be provided in the absence of any other waiver service when the consultation given to informal caregivers is necessary to prevent institutionalization.
- C. Who May Receive the Service** Therapeutic Consultation services are available only to MR waiver recipients.

M1440.213 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

- A. What is PERS** PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.
- B. Relationship to Other Services** An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.
- C. Who May Receive the Service** PERS is available only to EDCD recipients who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

M1440.214 PREVOCATIONAL SERVICES

- A. What are Prevocational Services** *Prevocational Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join in the*

general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs).

- B. Relationship to Other Services*** *This service is available only to persons receiving Day Support Services.*
- C. Who May Receive the Service*** *This service is available only to recipients of the DS Waiver.*

- f. Assiniboine Tribe of Fort Peck Montana [ref. P.L. 98-124]
- g. Assiniboine Tribe of Port Belknap [ref. P.L. 98-124]
- h. Shoshone and Arapaho Tribes of Wind River Reservation of Wyoming [ref. P.L. 98-64].

**21. Indian Trust
or Restricted
Land
Payments**

Income from individual interests in Indian Trust or Restricted Lands up to \$2,000 per year in payments is excluded [ref. P.L. 103-66].

**22. Walker v.
Bayer
Settlement
Payments**

The following payments from the settlement of the Walker v. Bayer Corp., et.al., lawsuit (sometimes called the “Hemophilia Litigation Settlement”) are excluded as income: [ref. P.L.105-33].

- a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., or
- b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of
 - December 31, 1997, or
 - the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

The **interest** received on these excluded funds is NOT excluded and must be counted as income in the month received.

23. Home Produce

Home produce consumed by the individual or his household is excluded as income. Proceeds from the sale of home produce ARE counted as earned or unearned income [ref. 1612(b)(8)].

**C. What Is NOT
Income For All
Covered Groups
EXCEPT F&C
MN**

The items below are NOT income when determining eligibility for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

**1. Specific VA
Payments**

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

- a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

NOTE: This applies to *all LTC recipients*, including *those patients who reside in* the Veterans Care Center in Roanoke, Va.

- b. Payments for unusual medical expenses.
- c. Payments made as part of a VA program of vocational rehabilitation.
- d. VA clothing allowance.
- e. Any pension paid to a nursing facility patient who is
 - a veteran with no dependents, or
 - a veteran's surviving spouse who has no child.

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to *all LTC recipients*, including *those patients who reside in the Veterans Care Center in Roanoke, Va.*

- f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

**2. VA
Augmented
Benefits**

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

**3. Return of
Money**

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

**5. Austrian
Social
Insurance**

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

**6. Native
American
Funds**

- a. Seneca Nation Settlement Act [ref. P.L. 101-503]
- b. Yakima Indian Nation [ref. P.L. 99-433]
- c. Papago Tribe of Arizona [ref. P.L. 97-408]
- d. Shawnee Indians [ref. P.L. 97-372]

- | | |
|-------------------------------------|---|
| 6. Domestic Travel Tickets | Gifts of domestic travel tickets [1612(b)(15)]. |
| 7. Victim's Compensation | Victim's compensation provided by a state. |
| 8. Tech-related Assistance | Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407]. |
| 9. \$20 General Exclusion | <p>\$20 a month general income exclusion for the unit.</p> <p>EXCEPTION: Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.</p> |
| 10. PASS Income | Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)]. |
| 11. Earned Income Exclusions | <p>The following earned income exclusions are not deducted for the 300% SSI group:</p> <ul style="list-style-type: none"> a. <i>In 2005, up to \$1,410 per month, but not more than \$5,670 in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].</i> <li style="margin-left: 40px;"><i>In 2006, up to \$1,460 per month, but not more than \$5,910 in a calendar year, of the earned income of a blind or disabled student child</i> b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)]. c. \$65 of earned income in a month [1612(b) (4)(C)]. d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)]. e. One-half of remaining earned income in a month [1612(b) (4)(C)]. f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)]. g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)]. |
| 12. Child Support | Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)]. |

13. Native American Funds

The following Native American funds (only exclude for ABD MN groups):

- a. Puyallup Tribe [ref. P.L. 101-41]
- b. White Earth Reservation Land Settlement [ref. P.L. 99-264]
- c. Chippewas of Mississippi [ref. P.L. 99-377]
- d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
- e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
- f. Wyandotte Tribe [ref. P.L. 98-602]
- g. Chippewas of Lake Superior [ref. P.L. 99-146]
- h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
- i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
- j. Wisconsin Band of Potawatomi [ref. P.L. 100-581]
- k. Seminole Indians [ref. P.L. 101-277]
- l. receipts from land distributed to:
 - Pueblo of Santa Ana [ref. P.L. 95-498]
 - Pueblo of Zia [ref. P.L. 95-499].

14. State/Local Relocation

State or local relocation assistance [1612(b) (18)].

15. USC Title 37 Section 310

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED**M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS****A. Policy - Individual in An Institution for Less Than 30 Days**

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of “institutionalization” is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the “institutionalization” definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual’s income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual’s income eligibility.

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME**M1470.001 OVERVIEW****A. Introduction**

This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. This post-eligibility treatment of income is called **patient pay**.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, ICF-MR or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services.

The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The provider collects the patient pay from the patient or his authorized representative.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not affect the patient's Medicaid eligibility. However, if the patient pay is not paid to or collected by the provider, the EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

C. Patient Pay Definition

"Patient pay" is the amount of the LTC patient's income which must be paid as his share of the LTC services cost. This amount is shown on the DMAS-122 to the provider and on the "Notice of Obligation for Long-Term Care Costs" to the patient.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY**A. Gross Income**

Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

**B. Income Counted
For Patient Pay**

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

**1. Aid &
Attendance
and VA
Pension
Payments**

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of \$90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a spouse or dependent child, or
- a deceased veteran's surviving spouse who does not have a dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to *all LTC recipients*, including *those patients who reside in the Veterans Care Center in Roanoke, Va.*

**2. Advance
Payments To
LTC Providers**

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay.

Advance payments which will not be refunded are usually made to reduce the recipient's resources to the Medicaid limit.

**C. Income Excluded
As Patient Pay
Income**

All income listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Other types of income excluded from patient pay are listed below.

1. SSI Payments

All SSI payments are excluded from income when determining patient pay.

**2. Certain
Interest
Income**

- a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.
- b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to \$10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.
 - Verify interest income at application and each scheduled redetermination.
 - If average interest income per month exceeds \$10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments are not income for patient pay (the patient or his representative should be advised to appeal the withholding).

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)
2. Dependent Child Allowance (M1470.420)
3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE**A. Individuals**

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance. The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

1. Basic Maintenance Allowance**a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver**

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance deduction that equals the monthly SSI individual payment limit (see M0810.002 A. 2.):

- EDCD Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- *DS Waiver*

b. AIDS Waiver

Patients under the AIDS waiver are allowed a monthly basic personal maintenance allowance that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3.).

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for representative payee or "power of attorney" fees or expenses.

**3. Special
Earnings
Allowance for
Recipients in
EDCD, DD,
MR or DS
Waivers**

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (see M0810.002 A. 3.) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #9: (Using January 2005 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$ 928.80) to the 200% of SSI maximum (\$ 1,158.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 579.00	CBC personal maintenance allowance
+ 928.80	special earnings allowance
\$ 1,507.80	total personal maintenance allowance

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

**1. Zero Patient
Pay
Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, **deny** the request.

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

**2. Allowable
Non-covered
Expenses**

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

- 1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients).

NOTE: For Medicaid CBC recipients who have Medicare Part B, medical supplies and equipment are often covered by Medicare Part B. The coinsurance or deductible is covered by Medicaid when these supplies/equipment are obtained from a Medicare/Medicaid enrolled supplier. Do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

- 2) routine dental care, necessary dentures and denture repair for recipients 21 years of age and older;
- 3) routine eye exams, eyeglasses and eyeglass repair;
- 4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- 5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- 6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- 7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- 8) *copayments for prescription drugs obtained under Medicare Part D.*

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

- a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:
 - diabetic and blood/urine testing strips,
 - bandages and wound dressings,
 - standard wheelchairs,
 - air or egg-crate mattresses,
 - IV treatment,
 - splints,
 - certain prescription drugs (placebos).

The Medicaid rate of \$55 per diem is projected for a 31-day month and equals \$1,705. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of \$1,730 exceeds the Medicaid rate of \$1,705, Mr. Knight is not eligible until he actually incurs medical expenses that equal or exceed the spenddown liability.

On August 3, the worker using actual incurred facility costs re-evaluates his spenddown for July. His spenddown eligibility is determined by comparing the private cost of care for July (\$65/day x 31 days= \$2,015) to his spenddown liability of \$1,730. Because the spenddown liability (\$1,730) is less than the private cost of care for July (\$2,015), he met his spenddown in July by incurring the private facility cost. Mr Knight is enrolled *for a* closed period of eligibility, beginning July 1, 1999 and ending July 31, 1999.

His old bill of \$100 is deducted as a noncovered expense because this is an initial application and the bill was incurred prior to the retroactive period. The nursing facility cost is NOT deducted. His patient pay for July is calculated as follows:

His dependent child allowance is calculated:

\$ 400	MN limit for 2 (Group III)
- 0	children's income
\$ 400	dependent children's allowance
\$2,000	total patient pay gross income
- 30	personal needs allowance
- 400	dependent children allowance
- 100	old bill incurred in March 1999
- 100	health insurance premium
\$1,370	remaining income for patient pay (July)

The worker compares the remaining income for patient pay to the facility's Medicaid rate for July (\$1,705). Because the remaining income for patient pay is less than the Medicaid rate, Mr. Knight's patient pay for July is \$1,370.

M1470.630 CBC PATIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

Community-based care (CBC) patients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for CBC waiver services. The monthly CBC expenses are determined retrospectively; they CANNOT be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The CBC expenses, along with other allowable medical and dental expenses, are deducted daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the *monthly* spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month, and ending the last day of the month.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider(s). Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

- a. a personal needs allowance (per M1470.410),
- b. a dependent child allowance, if appropriate (per M1470.420),
- c. any allowable noncovered medical expenses (per M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

**6. CBC with
Special
Earnings
Allowance**

EXAMPLE #20: (Using January 2000 figures)

Mr. R. lives in Group III and is approved by the screener for Medicaid CBC under *a waiver with a special earnings allowance* (see M1470.410.A.3). He applied for Medicaid on January 3. He has no spouse or dependent child. He works 22 hours a week. His income is \$800 monthly SS and \$2,000 gross earnings, which exceeds the CNNMP 300% of SSI limit.

His monthly countable earnings for January are determined:

\$2,000.00	gross earnings
<u>- 65.00</u>	exclusion
1,935.00	remainder
<u>- 967.50</u>	½ the remainder
\$ 967.50	countable earnings

His spenddown liability is calculated:

\$ 967.50	countable earnings
<u>+ 800.00</u>	SSA
1,767.50	total MN income
<u>- 20.00</u>	general income exclusion
\$1,747.50	countable income
<u>- 325.00</u>	MNIL for Group III
\$1,422.50	spenddown liability

He is placed on a 1-month spenddown for each month in the certification period of January 1 through December 31. On February 1, Mr. R. requests that his January spenddown be re-evaluated and he submits his medical bills.

He received personal care services for 5 hours per day, seven days per week, on all days in January. The private rate for his care was \$100 per day. The private cost of care in January was \$3,100. Because the cost of care was greater than his spenddown liability, he met the spenddown in January by the cost of care alone. Mr. R is enrolled in Medicaid effective January 1 through January 31. To determine his patient pay for January, the worker calculated his personal needs allowance first:

\$1,536.00	special earnings exclusion (M1470.410)
<u>+ 512.00</u>	basic personal allowance
\$2,048.00	personal maintenance allowance

His January patient pay is calculated as follows:

\$2,800.00	total gross monthly income
<u>-2,048.00</u>	personal maintenance allowance
\$ 752.00	remaining income for patient pay for (January)

The worker compares the Medicaid rate for CBC waiver services of \$1,627.50 (155 hours in January multiplied by \$10.50 per hour) to the remaining income of \$752. Because the remaining income is less than the Medicaid rate, Mr. R's patient pay for January is \$752.

M1470.800 COMPLETING THE DMAS-122 FORM**A. Introduction**

The DMAS-122 is the service provider's authorization to bill Medicaid for the patient's long-term care. The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The patient pay amount will not be paid by Medicaid; the provider must collect the patient pay from the patient or his authorized representative.

B. Purpose

Use the DMAS-122 to keep the provider informed on a current basis of the amount to be paid by or on behalf of the patient for care (the patient pay). The DMAS-122 must be completed and sent to the provider who collects the patient pay no later than 45 days from the date of application and 30 days from the date of a reported change. If the recipient has more than one provider, the DMAS-122 is sent to the provider as specified in 2. below.

The DMAS-122 is also used by the provider to inform the local DSS of a patient's admission to care, to request patient pay information and to inform the local DSS about changes in the patient's circumstances.

1. When to Use

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, when the recipient's Medicaid coverage is canceled or changed to limited coverage, such as QMB. The EW must update the DMAS-122 and send it to the provider or case manager whenever the patient's income or deductions change and must update the DMAS-122 at least every 12 months even if the patient's income and deductions do not change.

A currently dated DMAS-122 must be completed and sent to the provider or case manager when the annual redetermination is completed, if a DMAS-122 form was not sent to the provider or case manager within the past 12 months.

**2. Where to Send
the DMAS-122****a. Facility Patients**

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

b. CBC Waiver Patients

- 1) For MR *and* DS waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.
- 2) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager
Technology Assisted Waiver Program
Division of Appeals & Long-term Care
DMAS
600 E. Broad Street
Richmond, VA 23219

- 3) For EDCD recipients who have chosen consumer-directed services, send the DMAS-122 to the Service Facilitator. For all other EDCD waiver recipients, follow the instructions in 5) below.
- 4) *For DD waiver recipients, send the DMAS-122 to the Case Manager.*
- 5) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services:
 - a) send the DMAS-122 to the personal care services provider or adult day health care provider.
 - b) If the patient receives both personal care and adult day health care, send the DMAS-122 to the personal care provider.
- 6) Except for Technology- Assisted Waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Unit **only upon request** from that unit. Upon request from the CBC Unit, send a copy of the DMAS-122 to that unit at the following address:

CBC Unit
DMAS Division of Appeals & Long-term Care
600 E. Broad Street
Richmond, VA 23219.

M1470.810 MEDICARE PART A SNF COVERAGE

- | | |
|--|---|
| A. Introduction | When a Medicaid recipient's skilled nursing facility (SNF) care is covered by Medicare Part A and/or a Medicare supplement policy, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the third party payments. |
| B. Medicare Part A SNF Coverage | Medicare Part A will cover the first 100 days of skilled nursing facility (SNF) care when the patient is admitted to a SNF directly from a hospital. Medicare covers (pays) in full the first 20 days of SNF care. For the 21st through 100th day of SNF care, Medicare pays all but the daily Medicare coinsurance amount. Medicaid pays any Medicare coinsurance amount that remains after the patient pay for the month is deducted. |
| 1. QMB Only Recipients | For a QMB-only Medicaid recipient who remains QMB-only throughout the admission, Medicaid will cover the Medicare SNF coinsurance for the 21st through 100th day. Medicaid will NOT cover SNF care beyond 100 days for a |

QMB-only recipient. Medicaid does not cover SNF care for the SLMB, QDWI, or QI-covered groups.

When a QMB-only recipient is admitted and remains QMB-only throughout the admission, and Medicare covers the SNF care, the worker must determine patient pay for the month(s) in which the 21st through the 100th days occur, according to M1470.200 and M1470.310, and must send a DMAS-122 to the facility. When the QMB-only recipient has Medicare and Medicaid and no other insurance, check the box on the DMAS-122 “has Medicare Part A insurance”. When the QMB-only recipient has other health insurance that supplements Medicare, check the boxes on the DMAS-122 “has Medicare Part A insurance” and “has other health insurance”.

If the QMB-only recipient is admitted to a SNF and Medicare is NOT covering the care, send a DMAS-122 to the facility provider and check the box on the DMAS-122 “is eligible for QMB Medicaid only”. Do not show any patient pay information on the DMAS-122.

2. All Other Recipients

For all Medicaid recipients except the ABD MI covered groups, Medicaid will cover the Medicare coinsurance for the 21st through the 100th day, and medically necessary SNF care after 100 days. The worker must determine patient pay for the month(s) in which the recipient is a patient in the facility, according to sections M1470.200 and M1470.310, and must send a DMAS-122 to the facility.

a. Medicare & Medicaid Only

For Medicaid recipients who have Medicare Part A but no Medicare supplement or other health insurance, check the box on the DMAS-122 “has Medicare Part A insurance.”

b. Medicare and Medicare Supplement Health Insurance

For Medicaid recipients who have Medicare Part A and Medicare supplement or other health insurance that covers SNF care, check the boxes on the DMAS-122 “has Medicare Part A” and “has other health insurance”.

C. Example

EXAMPLE #21: A QMB-only Medicaid recipient from a Group III locality is admitted to a SNF directly from a hospital on June 4. He remains QMB-only because his resources exceed \$2,000 but are less than the \$4,000 QMB resource limit. He has a Medicare supplement health insurance policy. His only income is \$678 SS. He is already on the Medicare Buy-in.

The DMAS-122 for June and July is completed and the boxes stating the patient “is eligible for QMB Medicaid only”, “has Medicare Part A” and “other health insurance” are checked. No patient pay information is entered.

C. Procedures

1. **Required Contact**

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact whomever is designated as legally able to make the patient's financial decisions and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. **Reduce Excess Resources**

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1

Determine amount of excess resources (total resources minus the resource limit).

Step 2

Determine the monthly Medicaid rate:

- for a facility patient, the monthly rate is the facility's Medicaid per diem rate multiplied by *31 days*.
- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3

Add the amount of excess resources to the current patient pay.

Step 4

If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5

If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. **Example--
Recipient Reduces
Resources**

EXAMPLE #25: An institutionalized Medicaid recipient's resources accumulate to \$2,200 in February. His monthly income is \$500 SS and \$100 VA Compensation. His patient pay of \$570 is less than the Medicaid rate. He pays the amount of his excess resources (\$200) to the nursing facility as part of his March patient pay, so he remains eligible.

\$ 500	SS
<u>+100</u>	VA Compensation
\$ 600	total gross income
<u>- 30</u>	personal needs allowance
\$ 570	current patient pay (prior to adding excess resources)

$\$ 570$ *current patient pay*
 $+ \underline{200}$ *excess resources*
 $\$770$ *patient pay for March only*

His patient pay for April and subsequent months is calculated:

$\$ 500$ SS
 $+ \underline{100}$ VA Compensation
 $\$ 600$ total gross income
 $- \underline{30}$ personal needs allowance
 $\$ 570$ patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount shown on the DMAS-122 by the local social services department as being available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay shown on the DMAS-122. Patient pay can be adjusted when certain criteria, specified in the

- has elected hospice services

applies for Medicaid. The spousal share is used in determining the institutionalized individual's resource eligibility.

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The \$2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Virginia DSS, Volume XIII, Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws.** The following resources are excluded: [1924(c)(5)]

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments *received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months;* and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

C. Procedures

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

1. Case Record Number

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name.

If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

2. Determining the First Continuous Period of Institutionalization

The resource assessment is based on the couple's resources owned **on the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

8. Notification Requirements**a. When the Assessment Is Not Completed**

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION**A. Introduction**

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy**1. Resource Assessment**

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in the Virginia DSS Volume XIII, Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws.** The following resources are excluded:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments *received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months;* and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month** of the first continuous period of institutionalization, and
- all resources owned as of the application month.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Use the Medicaid Resource Assessment form (#032-03-816) to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization.

institutionalization) were \$131,000. The spousal share is $\frac{1}{2}$ of \$131,000, or \$65,500.

On the Medicaid Resource Assessment form, the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$31,000

\$131,000 Total Value of Couple's Countable Resources

\$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount (\$65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources at the time of application and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

C. "Institutionalized Spouse Resource Eligibility Worksheet"

Use the "Institutionalized Spouse Resource Eligibility Worksheet" to determine the institutionalized spouse's resource eligibility. The worksheet is in Appendix 4 to this subchapter.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard

\$19,908 1-1-06

\$19,020 1-1-05

C. Maximum Spousal Resource Standard

\$99,540 1-1-06

\$95,100 1-1-05

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid in the application month if the difference between the couple's total countable resources **at the time of application** and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met

When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

2. Aid Category

a. If the institutionalized spouse does NOT have Medicare Part A:

- Aged = 018
- Blind = 038
- Disabled = 058
- Child Under 21 in ICF/ICF-MR = 098
- Child Under Age 18 = 088
- Juvenile Justice Child = 085
- Foster Care/Adoption Assistance Child = 086
- Pregnant Woman = 097

b. If the institutionalized spouse has Medicare Part A:

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):

1) When income is less than or equal to the QMB limit, enroll using the following ACs:

- Aged = 028
- Blind = 048
- Disabled = 068

2) When income is greater than the QMB limit, enroll using the following ACs:

- Aged = 018
- Blind = 038
- Disabled = 058

3. Patient Pay

Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- | | | | |
|--|------------|-----------------------------|---------|
| B. Monthly Maintenance Needs Standard | \$1,603.75 | 7-1-05 | |
| | \$1,561.25 | 7-1-04 | |
| C. Maximum Monthly Maintenance Needs Allowance | \$2,488.50 | 1-1-06 | |
| | \$2,377.50 | 1-1-05 | |
| D. Excess Shelter Standard | \$481.13 | 7-1-05 | |
| | \$468.37 | 7-1-04 | |
| E. Utility Standard Deduction (Food Stamps Program) | \$227 | 1 - 3 household members | 10-1-05 |
| | \$282 | 4 or more household members | 10-1-05 |
| | \$229 | 1 - 3 household members | 10-1-04 |
| | \$283 | 4 or more household members | 10-1-04 |

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

- A. Policy** After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

$$\begin{array}{rcl}
 \$875 & \text{gross earned income} & \\
 - \underline{75} & \text{first \$75 per month} & \\
 800 & \text{remainder} & \\
 \div \underline{2} & & \\
 400 & \text{\frac{1}{2} remainder} & \\
 + \underline{75} & \text{first \$75 per month} & \\
 \$475 & \text{which is } > \$190 &
 \end{array}$$

His personal needs allowance is calculated as follows:

$$\begin{array}{rcl}
 \$ 30.00 & \text{basic personal needs allowance} & \\
 +190.00 & \text{special earnings allowance} & \\
 + \underline{17.50} & \text{guardianship fee (2\% of \$875)} & \\
 \$237.50 & \text{personal needs allowance} &
 \end{array}$$

2. Medicaid CBC Waiver Services

a. Maintenance Allowance

Deduct the appropriate maintenance allowance for one person, based on the specific Medicaid CBC waiver under which the individual receives LTC services:

- 1) *Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, and Day Support (DS) Waiver*: the monthly SSI individual payment limit for one person.
- 2) *AIDS Waiver*: 300% of the SSI limit (see M0810.002 A. 3.).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance *For DD, DS and MR Waivers*

EXAMPLE #19: *(deleted)*

For DD, DS and MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- a) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI per month.
- b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

EXAMPLE #20: *(Using January 2000 figures)*

A working patient *in the MR Waiver* is employed 18 hours per week. *He has* gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- <u>1,024.00</u>	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ <u>928.80</u>	special earnings allowance
\$1,440.80	personal maintenance allowance

- D. Community Spouse Monthly Income Allowance**
- The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.
- 1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)**
- Calculate the minimum monthly maintenance needs allowance using the following procedures (**do NOT round any cents to a dollar**):
- a. the monthly maintenance needs standard, plus
 - b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below **exceeds** the excess shelter standard.
- Allowable expenses are:
- 1) rent,
 - 2) mortgage (including interest and principal),
 - 3) taxes and insurance,
 - 4) any maintenance charge for a condominium or cooperative, and
 - 5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.
- The utility standard deduction for a household of 1-3 members is different than the deduction for households of 4 or more members.
- 2. Maximum Allowance**
- The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.
- 3. Court or DMAS Hearing Officer Ordered Amount**
- If a court support order requires support in an amount that is greater than the minimum monthly maintenance needs allowance calculated above, or if a DMAS Hearing Officer has determined that an amount greater than the one calculated above is needed because of exceptional circumstances resulting in extreme financial duress, DO NOT use the procedures in D.1. and D.2. above for the minimum monthly maintenance needs allowance, and **do not calculate the community spouse monthly income allowance**. The community spouse monthly income allowance is the amount designated by the court order or the DMAS Hearing Officer.

**4. Calculate
Community
Spouse
Monthly
Income
Allowance**

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals \$0).

c. Remainder Greater Than \$0

If the remainder is greater than \$0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse's patient pay.

d. Remainder Less Than or Equal To \$0

If the remainder is \$0 or less, the community spouse monthly income allowance is \$0.

e. Community Spouse Choice

The community spouse can choose to accept a lesser amount of the community spouse monthly income allowance. If the community spouse chooses to accept a lesser amount, the lesser amount is the community spouse monthly income allowance that is deducted from the institutionalized spouse's patient pay.

**5. Deduct From
Patient Pay**

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS:

- the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse, OR

1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
-106.25	community spouse monthly income allowance
<u>-468.75</u>	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
<u>-200.00</u>	old bills
\$474.50	remaining income for patient pay (July)

Her patient pay for August is calculated as follows:

\$1,000.00	SS
<u>+ 400.00</u>	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
<u>- 468.75</u>	family member's monthly income allowance
795.00	
- 120.50	Medicare premium & health insurance premium
\$ 674.50	remaining income for patient pay (August)

Mrs. Bay's patient pay for September is calculated as follows:

\$1,000.00	SS
<u>+ 400.00</u>	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
<u>- 468.75</u>	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
\$ 720.00	remaining income for patient pay (September)

The worker completes a DMAS-122 showing her patient pay for July, August and September and sends it to the facility. The worker completes and sends a "Notice of Obligation" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

1. Patient Pay Deductions

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility or CBC cost of care.

2. When Patient Pay Is Not Required

Intermediate Care Facility for the Mentally Retarded (ICF-MR) and Institution for Mental Diseases (IMD) services are not covered for medically needy (MN) eligible recipients. Therefore, a patient pay determination is not required when a MN enrolled recipient resides in an IMD or ICF-MR.

B. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

- Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450).
- Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460).
- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

- A. Policy** **An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month**, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his community spouse and family member allowances, and his personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.
- B. Procedures** Determine patient pay for the month in which the spenddown is met using the procedures below.
- 1. Patient Pay Gross Monthly Income** Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).
- 2. Subtract Patient Pay Deductions** Subtract the following from the patient pay gross monthly income in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.
- a. a personal needs allowance (per section M1480.430 C.),
- b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

- c. a family member's income allowance, if appropriate (per section M1480.430 E.),
- d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,
- e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

3. Patient Pay Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

4. DMAS-122 Complete and send a DMAS-122 form to the facility for the month in which the spenddown was met, showing the individual's begin and end date of Medicaid coverage in the month, and the patient pay for the month.

5. Notice of Obligation Complete and send a "Notice of Obligation for Long-term Care" to the recipient and/or his authorized representative for the month in which the spenddown was met, showing the individual's patient pay for the month.

C. Example--Facility Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: (Using July 2000 figures)

Mr. Hay is an institutionalized spouse who applied for Medicaid in *July*. He was admitted to the facility the prior November. He has a monthly CSA benefit of \$1,700 and a monthly Seminole Indian payment of \$235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs \$75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of \$500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay's total income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for *July*. The MN determination results in a monthly spenddown liability of \$1,355:

\$1,700	monthly MN income (Seminole Indian payment excluded)
- <u>20</u>	exclusion
1,680	countable MN income
- <u>325</u>	MN limit for 1 (Group III)
\$1,355	spenddown liability for month

The facility's Medicaid rate is \$45 per day, or \$1,395 for a 31-day month. By projecting the month's cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective *July* 1. He is enrolled in Medicaid effective *July* 1, with a PD of 18.

**2. Notice of
Obligation for
Long-Term
Care Costs
(#032-03-062)**

The “Notice of Obligation for Long-term Care Costs” notifies the patient of the amount of patient pay responsibility. The “Agency” copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider.

Failure to return a signed form has no impact on the individual’s eligibility status. Processing of the application shall not be delayed pending the return of the signed form. This form is a voluntary agreement only.

**3. Patient
Information
DMAS-122**

The Patient Information form DMAS-122 is a two-way communication form designed to facilitate communication between the local agency and the LTC services provider. Sometimes, the DMAS-122 is initiated by the local agency; sometimes, the form is initiated by the LTC provider.

The DMAS-122 form

- notifies the LTC provider of a patient’s Medicaid eligibility status;
- provides confirmation of the amount of income an eligible patient must pay to the provider toward the cost of care;
- reflects changes in the patient's level of care;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

a. When to Complete A DMAS-122

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB, SLMB, QI-1, QI-2 or QDWI coverage, or **whenever the recipient's patient pay amount changes.**

The EW must update the DMAS-122 and send it to the provider at least once per year (even if the patient pay does not change). If the patient pay does not change, the updated DMAS-122 can be sent when the annual redetermination is completed.

b. Where To Send A DMAS-122

1) Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

2) Medicaid CBC Waiver Patients

- a) For MR *or* DS waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.
- b) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager
Technology Assisted Waiver Program
DMAS
600 E. Broad Street
Richmond, VA 23219

- c) For *EDCD* recipients *who have chosen consumer-directed services*, send the DMAS-122 to the *Service Facilitator*. *For all other EDCD waiver recipients, follow the instructions in e) below.*
- d) For DD waiver recipients, send the DMAS-122 to the *Case Manager*.
- e) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services send the DMAS-122 to the personal care services provider *or adult day health provider*. *If the patient receives both personal care and adult day health, send the DMAS-122 to the personal care provider.*
- f) Except for Technology-Assisted Individuals waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Waiver Unit **only upon request** from that unit. Upon request from the CBC Waiver Unit, send a copy of the DMAS-122 to the unit at the following address:

CBC Waiver Unit
DMAS
600 E. Broad Street
Richmond, VA 23219

c. Revising DMAS-122 Forms

DMAS-122 forms are not revised retroactively (after the month in question has passed) EXCEPT when

- the patient dies, or
- the patient moves to another facility or changes LTC providers.

Go to subchapter M1470 for detailed instructions for completing and revising the DMAS-122 form.

M1510.000 ENTITLEMENT POLICY & PROCEDURES**M1510.100 MEDICAID ENTITLEMENT**

- A. Policy** If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month. However, if the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.
- B. SSI Entitlement Date Effect on Medicaid** SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.
- C. Procedures** The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:
- M1510.101 Retroactive Eligibility & Entitlement
 - M1510.102 Ongoing Entitlement
 - M1510.103 Disability Denials
 - M1510.104 Foster Care Children
 - *M1510.105 Delayed Claims*

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT**A. Definitions**

- 1. Retroactive Period** The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be CN, CNNMP or MI in one or two months and MN in the third month, or any other combination of classifications.
- 2. Retroactive Budget Period** The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

- B. Policy** An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification

1. CN, CNNMP, MI

The retroactive budget period for categorically needy (CN), categorically needy non-money payment (CNNMP) and medically indigent (MI) covered groups (categories) is one month.

CN, CNNMP or MI eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. Medically Needy (MN)

In the retroactive period, the **MN budget period is always all three months** in the retroactive period. Unlike the CN, CNNMP or MI, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for MI Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.

programs. The agency has ready access to Food Stamp and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files. Income verification *no older than 6 months old may* be used unless the agency has reason to believe it is no longer accurate. *It is not necessary to retain a copy of verifications of income in the case record. If a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source and a description of the information.*

When the recipient has reported that he has no income (\$0 income), the recipient must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the recipient has reported \$0 income.

The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

When an ongoing F&C Medicaid recipient applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.

The recipient is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.

2. Medicaid Renewal Form

When a Medicaid Renewal form is required, the form must be sent to the recipient no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the recipient to sign and return or can be mailed to the recipient for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the recipient has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

Special Requirements for Certain Covered Groups

1. Pregnant Woman

A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. Cancel her coverage as a pregnant woman effective the last day

of the month in which the 60th day following the end of her pregnancy occurs. Reinstate coverage in the Family Planning Services (FPS) limited-coverage group effective the first day of the following month unless information available to the agency establishes her eligibility in a full-benefit covered group. Do not use change transactions to move an individual between full and limited coverage

2. FPS

The Medicaid eligibility of women in the FPS covered group must be evaluated 12 months following the end of the pregnancy. If eligible in a full-benefit covered group, cancel her FPS coverage in the MMIS using cancel code "008" effective the last day of the month prior to the month of eligibility for full coverage, and reinstate full coverage the first day of the month of eligibility for full coverage. If eligible only for FPS, she is entitled to an additional 12 months of FPS coverage.

**3. Newborn Child
Turns Age 1**

A renewal for a child enrolled as a Newborn Child Under Age 1 must be done before VaMMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- an application (see M0120.300)
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

**4. Child Under
Age 19
(FAMIS Plus)**

The Medicaid eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled MI child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is enrolled in FAMIS and there is no break in coverage. **Do not use change transactions to move a child between Medicaid and FAMIS.** If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage

**5. MI Child
Turns Age 19**

When an MI child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

**6. Child Turns Age
21**

When a recipient who is enrolled as a child under age 21 attains age 21, determine if the recipient meets the definition for another covered

The unit must be instructed to retain verifications of all earnings received and the costs of child care during each month of the extension, and to send the "Medicaid Extension Earnings Report" and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period.

The names of the three months in the three-month period must be written out on the notice form and the report form whenever either form is sent to the family unit.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report", with the earnings and child care cost verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by the Medicaid computer if the correct *follow-up* code and effective date of the 12-month extension are entered in the base case information fields. If the code and effective date are not entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

The Medicaid computer will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial *follow-up* code and extension effective date were entered correctly, and the code is not updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the advance notice of Medicaid cancellation and must cancel the family's coverage in the computer after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid under another covered group or classification must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income, and resources. If the child is eligible, change the child's enrollment to the appropriate *aid category*

before the cut-off date of the sixth extension month. If not eligible, leave the child's enrollment (and the base case *follow-up code and follow-up date fields*) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the sixth extension month, the computer will cancel coverage. The agency must then reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The *follow-up* code must be changed in the Medicaid computer base case information when the report is received in order for Medicaid to continue. No action is taken on the first three-month period's earnings and the extension continues.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month) with the earnings and child care cost verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

The Medicaid computer will automatically send this notice if the *follow-up* code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. The Medicaid computer will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are, illness or injury of family member(s) who is capable of obtaining and sending the material; agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid under another category or classification must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income, and resources. If the child is eligible, change the child's

enrollment to the appropriate *aid category* before the **cut-off date** of the eighth extension month. If not eligible, leave the child's enrollment (and the base case *follow-up code and follow-up date fields*) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eighth extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the base case *follow-up code* in the Medicaid computer immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

- 1) no child under age 18, or under age 19 if in school, lives with the family;
- 2) the family disenrolls from a group health plan that DMAS has determined cost-effective or fails to pay the premium to maintain the group health plan;
- 3) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to the caretaker/relative's involuntary lay-off, the business closed, etc., the caretaker/relative's illness or injury, or other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work); or
- 4) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% poverty income limit appropriate to the family unit size.

See subchapter M0710, Appendix 7 for the 185% poverty income limits.

d. Calculate Family's Gross Earned Income

- 1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-

month period. “Gross” earned income is total earned income before any deductions or disregards. All earned income must be counted, including students’ earned income, JTPA earned income, children’s earned income, etc. No disregards are allowed.

- 2) Child care costs that are “necessary for the caretaker/relative’s employment” are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.
- 3) To calculate average gross monthly income:
 - add each month’s cost of child care necessary for the caretaker/relative’s employment; the result is the three-month’s cost of child care necessary for the caretaker/relative’s employment.
 - add the family unit’s total gross earned income received in each of the 3 months; the result is the family’s total gross earned income.
 - subtract the three-months’ cost of child care necessary for the caretaker/relative’s employment from the family’s total gross earned income.
 - divide the remainder by 3; the result is the average monthly earned income.
 - compare the average monthly earned income to the monthly 185% poverty limit for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member’s eligibility for Medicaid under another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family’s total income, including earned and unearned income, and resources. If eligible, change the enrollment to the appropriate *aid category* before cut-off in the eighth extension month.

- 2) If the family is ineligible because of excess income, cancel Medicaid coverage and place the family members who meet a medically needy covered group on spenddown.

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for the extension, no action is required until the ninth month of extension, except to be sure that the *follow-up* code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" with earnings and child care cost verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

The Medicaid computer will automatically send this notice if the correct code is in the base case information on the computer. If it is not, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. The Medicaid computer will automatically cancel coverage and send the advance notice if the report is not received on time and the *follow-up* code is not changed. Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid under another covered group must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, and resources. If eligible, change the child(ren)'s enrollment to the appropriate *aid category* before the **cut-off date** of the eleventh extension month. If not eligible, leave the child's enrollment (and the base case *follow-up code and follow-up date fields*) as it is and the computer will cancel the child(ren)'s coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eleventh extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child(ren) is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last day of the eleventh month of extension.

c. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the base case *follow-up* code in the Medicaid computer immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in 5.c. above applies. Calculate the family's income using the procedures in 5.d. above.

d. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to **extended** Medicaid coverage, review their eligibility for Medicaid under another category and/or classification. If not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension.

If the family is ineligible because of excess income and all other eligibility factors are met, cancel Medicaid and place the family members who meet a medically needy covered group on spenddown. **Send the Advance Notice of Proposed Action.**

e. Family Remains Entitled To Extended Medicaid

If the family remains entitled to extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination.

The Medicaid computer will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the *follow-up* code was updated correctly. Therefore, for any of the family members that remain eligible, the *AC* (if applicable) and the *follow-up* code must be changed before cut-off of the twelfth month.

If all eligibility factors are met except income, place the family members who meet a medically needy covered group on spenddown. **Send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month. The spenddown period begins the first day of the following month.

M1520.503 TRANSITIONAL MEDICAID BENEFITS

The Transitional Medicaid extension expired June 30, 2003 and was only applicable to VIEW participants who did not qualify for the Twelve-Month extension.

M1800 MEDICAL SERVICES**M1810.100 MEDICAID ELIGIBILITY CARD****A. Medicaid
Card Issuance**

A Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). *The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to ascertain the type of coverage and the begin date of coverage. The card is intended to be permanent.* Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

Exception: The following recipients do not receive a Medicaid card:

- individuals eligible for Medicare premium payment only, *and*
- *individuals enrolled in a closed period of coverage in the past with no ongoing coverage.*

**B. Use of the Medicaid
Card****1. General**

Local social services departments must provide recipients with information concerning use of the Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

**2. Foster Care
Children in
Institutional
Facilities**

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in a child caring institution or admitted to an institution for the mentally retarded. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

**3. Nursing
Facility
Patients**

Patients in long-term nursing facilities receive Medicaid cards. The nursing facility *also* receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility. Each patient's name, Medicaid number, and medical resources code is included on this listing.

This listing reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet" to Medicaid, and whom Medicaid has entered on its Long-Term Care Information computer subsystem. DMAS *staff* enters the patient information into the subsystem and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term care providers have been instructed to notify the LDSS of death or discharge via the DMAS-122

M1820.100 SERVICE PROVIDERS

**A. Enrollment
Requirement**

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services from DMAS and are available online at www.dmas.state.va.us.

**B. Out-of-
State Providers**

**1. Covered
Services**

Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

- a. the general custom of the eligible individual (e.g., a recipient living near the border of another state),
- b. needed by a non IV-E Foster Care child placed outside Virginia,
- c. necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or
- d. indicated because of referral to an out-of-state facility when preauthorized by DMAS.

DMAS will review all good cause requests. Only the following reasons, if applicable, will result in approval:

- quality of care,
- access issues,
- receipt of care at a Rural Health Clinic or Federally Qualified Health Center that is not enrolled with the current MCO as a participating provider, and
- extreme medical conditions.

**E. Enrollment
Corrections/
Changes**

DMAS pays a capitation rate for every month a recipient is enrolled in managed care regardless of whether the recipient receives medical services during the month. If a recipient is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

**F. Family Access to
Medical
Insurance
Security Plan
(FAMIS)
Managed Care**

FAMIS benefits are different than the benefits that children enrolled in MEDALLION, Medallion II, and Medicaid fee-for-service receive. The FAMIS benefit package is modeled after the Key Advantage benefit package available to state employees. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance.

The FAMIS benefit delivery system is available throughout the Commonwealth through either MCOs or FAMIS fee-for-service. In most of Virginia, children are enrolled with a contracted managed care organization. Whenever possible, DMAS offers FAMIS families a choice when receiving their health care. In most areas, enrollees may choose from at least two MCOs. In a few localities, however, there is currently only one MCO available to FAMIS enrollees. Children in these areas will be covered by the available MCO. They may not request an MCO change and are not eligible for the MEDALLION Program.

In a few areas of Virginia where there are no MCOs, children enrolled in FAMIS receive benefits through FAMIS fee-for-service. They have no co-payments and their benefits are similar to Medicaid. Refer to the FAMIS website at www.FAMIS.org for more information.

M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Long Term Care and Quality Assurance Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

Recipients in long-term care are reviewed at least once every six months to determine the continued need for long-term care. Their treatment and level of functioning is compared to the Medicaid long-term care regulations for nursing care. If a recipient no longer meets the regulations for long-term care, DMAS notifies the provider and the recipient at least 10 days in advance that Medicaid payment for the care will stop. The recipient has the right to appeal this decision. Long-term care providers have been instructed to notify the LDSS of discharge via the DMAS-122.

B. Client Medical Management Program

Recipients' utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by *DMAS*. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the Client Medical Management Program and required to select a primary physician and/or pharmacy or both.

Recipients identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to *DMAS*. The local agency service worker will be asked to interview the recipient and gather information for *DMAS*. Following receipt of that information by *DMAS*, the recipient's *MMIS* record will have the names and provider numbers of the selected physician and pharmacy on it. Recipients who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by *DMAS*.

- inpatient hospital services;
- intermediate care facility-mental retardation (ICF-MR) services;
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);
- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;
- nurse-midwife services;
- nursing facility care;
- optometrist services;
- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;
- outpatient hospital services;
- physical therapy and related services;
- physician services;
- podiatrist services;
- prescribed drugs;
- prosthetic devices;
- Rural Health Clinic services;
- skilled nursing facility services for individuals under age 21 years;
- transplant services; and
- transportation to receive medical services.

Explanations of some covered services are provided below:

**1. Clinic
Services**

Covered clinic services include therapeutic, rehabilitative, or palliative items or services, and renal dialysis furnished to an outpatient by or under the direction of a physician, in a certified facility which is organized and operated to provide medical care to outpatients.

**2. Community-
Based-Care
Waiver
Services**

Virginia provides services under community-based care (CBC) waivers to specifically targeted individuals. These services are not available to all Medicaid recipients. The CBC waivers are:

- Acquired Immunodeficiency Syndrome (AIDS) Waiver,
- Elderly *or* Disabled *With Consumer Direction (EDCD)* Waiver,
- Mental Retardation (MR) Waiver,
- Technology Assisted *Individuals* Waiver,
- Individual and Family Developmental Disabilities Support (DD) Waiver
- *Day Support (DS) Waiver, and*
- *Alzheimer's Assisted Living (AAL) Waiver.*

Services covered under the waivers are listed in M1410.040.

**3. Community
Mental
Health and
Mental
Retardation
Services**

Certain mental health and mental retardation services are covered for Medicaid-eligible recipients when provided by Medicaid-enrolled mental health providers.

Examples of community mental health services are mental health case management, psychosocial rehabilitation, mental health support, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services.

Mental retardation case management is available to recipients who are not enrolled in the Mental Retardation (MR) Waiver. Other community mental retardation services are available to recipients enrolled in the MR Waiver and include mental retardation case management, day support, residential support, and supported employment services.

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M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. There is no retroactive coverage in FAMIS. Case management and ongoing case maintenance, and selection for managed care are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for Medicaid due to excess income;
- he is under age 19 and a resident of Virginia;
- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);

- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

FAMIS alienage requirements are different from the Medicaid alienage requirements. Citizens and qualified aliens who entered before August 22, 1996 meet the citizenship/alienage requirements and are not subject to time limitations.

- a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:
 - refugees (see M0220.310 A. 2),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52)
- b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.

Appendix 4, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN

A Social Security number (SSN) or proof of application for *an* SSN (M0240) is **not** a requirement for FAMIS.

3. Assignment of Rights

Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

4. HIPP

Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to FAMIS.

D. FAMIS Nonfinancial Requirements

The child must meet the following FAMIS nonfinancial requirements:

1. Age Requirement

The child must be under age 19 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

2. Uninsured Child

The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

3. State Employee Prohibition

A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.

4. IMD Prohibition

The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated.

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Employer Sponsored Dependent Health Insurance

Employer sponsored dependent health insurance (ESHI) means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer sponsored insurance.

3. Family Member

When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, family member means parent(s), and a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

4. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- “any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.

Health benefit plan does not mean:

- *Medicare, Medicaid, State/Local Hospitalization;*
- accident only;
- credit or disability insurance;
- long-term care insurance;

- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Insured

means having creditable health insurance coverage or coverage under a health benefit plan.

6. Uninsured

means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy

A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to this chapter], or
- without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. Health Insurance Coverage Discontinued

A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated without good cause within 4 months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.

Example: A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within 4 months of November. He may be eligible in March because his insurance was terminated more than 4 months prior to March.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, *FAMIS Select*, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

E. Good Cause for Dropping Health Insurance

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the health insurance premiums for all family members exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

The parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage. Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

**B. Eligibility
Determination**

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS or the FAMIS CPU. Cases approved for FAMIS must be transferred to the FAMIS CPU for case management and ongoing case maintenance.

**C. Entitlement and
Enrollment**

Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth. There is no retroactive coverage in the FAMIS program.**

The *aid categories (ACs)* for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 133% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 133% FPL and ≤ 150% FPL

Because Medicaid and FAMIS are separate programs, Medicaid eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in Medicaid in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.

After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V000 to transfer the case to the FAMIS CPU. The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS.

**D. Notification
Requirements**

1. Notice of Action

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 days, the original application date will be honored.

**2. Transfer to
FAMIS CPU**

Once the enrolled case is transferred in MMIS and the notice is sent to the family, the eligibility worker must send to the FAMIS CPU:

- the original application *or ADAPT Statement of Facts, eligibility evaluation form* and verifications used to determine FAMIS eligibility, and
- the case record transfer form.

Cases must be sent to the FAMIS CPU, FIPS 976, via the courier the day of enrollment or the next working day.

The FAMIS CPU will send the local DSS the signed copy of the case transfer form confirming receipt of the case.

**3. Communica-
tion Between
Local DSS and
the FAMIS
CPU**

The Children's Health Insurance Communication form (see Appendix 3 to this chapter) is used to request cancellation of FAMIS coverage of children found eligible for Medicaid, report changes and communicate information between local DSS and the FAMIS CPU.

E. FAMIS Select

Under the FAMIS program, *a family who* has access to health insurance through *an employer, or wishes to purchase a private policy*, has the option of enrolling the family in *that* health plan. *This program that allows the choice of the private or employer's insurance instead of FAMIS is called "FAMIS Select."* Children enrolled in FAMIS whose families have access to *private or employer sponsored health insurance* coverage may qualify to have the State pay part of the family's share of the health insurance premium.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the child has access to *private or* employer sponsored health insurance. Families who have access to *such insurance* will receive information from DMAS about the benefits of enrolling in the *FAMIS Select* component of FAMIS and information about how to participate in the program. Participation in the *FAMIS Select* component is voluntary.

**F. 12-Month
Continuous
Coverage**

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

STATE AGENCY LISTING - 07/30/02

Accountancy, Board of
Accounts, Dept. of
Administration, Secretary of
Aging, Dept. for the
Agriculture and Consumer Services, Dept. of
Alcoholic Beverage Control, Dept. of
Arts, Virginia Commission for the
Atlantic States Marine Fisheries Commission
Attorney General, Office of the
Auditor of Public Accounts
Aviation, Dept. of
Bar Examiners, State Board of
Blind and Vision Impaired, Dept. for the
Blue Ridge Community College
Blue Ridge Hospital
Business Assistance, Virginia Dept. of
Capitol Police, Division of
Catawba Hospital
Center for Innovative Technology
Central State Hospital
Central Virginia Community College
Central Virginia Training Center
Charitable Gaming Commission
Chesapeake Bay Commission
Chesapeake Bay Local Assistance
Child Day Care & Early Childhood Programs,
 Virginia Council on
Christopher Newport University
Civil Air Patrol
College of William and Mary
Commerce and Trade, Secretary of
Commonwealth Center for Children and
 Adolescents
Commonwealth Competition Council
Commonwealth, Secretary of the
Commonwealths Attorneys Services Council
Community College System, Virginia
Compensation Board
Conservation and Recreation, Dept. of
Corporation Commission, State
Correctional Education, Dept. of
Corrections, Dept. of
Court of Appeals of Virginia

Credit Union, Inc., Virginia
Crime Commission, Virginia Stat
Criminal Justice Services, Dept. of
Dabney S. Lancaster Community College
Danville Community College
Deaf and Hard of Hearing, Dept. for the
Delmarva Advisory Council
Eastern Shore Community College
Eastern State Hospital
Economic Development Partnership, Virginia
Education, Dept. of
Education, Secretary of
Elections, State Board of
Emergency Management, Dept. of
Employment Commission, Virginia
Employment Dispute Resolution, Dept. of
Environmental Quality, Dept. of
Finance, Secretary of
Fire Programs, Dept. of
Forestry, Dept. of
Frontier Culture Museum of Virginia
Game and Inland Fisheries, Dept. of
General Services, Dept. of
George Mason University
Germanna Community College
Governor, Office of the
Gunston Hall
Health and Human Resources, Secretary of
Health Professions, Dept. of
Health, Dept. of
Higher Education for Virginia, State Council of
Hiram W. Davis Medical Center
Historic Resources, Dept. of
House of Delegates
Housing and Community Development, Dept. of
Housing Development Authority, Virginia
Housing Study Commission, Virginia
Human Resource Management, Dept. of
Human Rights, Council on
Information Technology, Dept. of
J. Sargeant Reynolds Community College
James Madison University
Jamestown-Yorktown Foundation

John Tyler Community College
Joint Commission on Health Care
Joint Legislative Audit and Review Commission
Judicial Inquiry and Review Commission
Juvenile Justice, Dept. of
Labor and Industry, Dept. of
Legislative Automated Systems, Division of
Legislative Services, Division of
Liaison Office, Virginia
Library of Virginia, The
Lieutenant Governor, Office of the
Local Government, Commission on
Longwood University
Lord Fairfax Community College
Lottery, Dept. of the
Marine Resources Commission
Marine Science, Virginia Institute of
Mary Washington College
Medical Assistance Services, Dept. of
Medical College of Virginia
Melchers Monroe Memorials
Mental Health, Mental Retardation & Substance
Abuse Services, Dept
Military Affairs, Dept. of
Milk Commission
Mines, Minerals and Energy, Dept. of
Minority Business Enterprise, Dept. of
Motor Vehicle Dealer Board
Motor Vehicles, Dept. of
Mountain Empire Community College
Museum of Fine Arts, Virginia
Museum of Natural History, Virginia
Natural Resources, Secretary of
New River Community College
Norfolk State University
Northern Virginia Community College
Northern Virginia Mental Health Institute
Northern Virginia Training Center
Office of Commonwealth Preparedness
Old Dominion University
Outdoors Foundation, Virginia
Parole Board, Virginia
Patrick Henry Community College
Paul D. Camp Community College
People With Disabilities, Virginia Board for
Piedmont Geriatric Hospital
Piedmont Virginia Community College
Planning and Budget, Dept. of

Port Authority, Virginia
Potomac River Fisheries Commission
Professional & Occupational Regulation, Dept. of
Public Broadcasting, Virginia
Public Defender Commission
Public Safety, Secretary of
Racing Commission, Virginia
Radford University
Rail and Public Transportation, Dept. of
Rappahannock Community College
Rehabilitation Center for the Blind & Visually
Impaired
Rehabilitative Services, Dept. of
Retirement System, Virginia
Richard Bland College (of William and Mary)
Science Museum of Virginia
Senate, Virginia State
Social Services, Dept. of
Southeastern Virginia Training Center
Southern Virginia Mental Health Institute
Southside Virginia Community College
Southside Virginia Training Center
Southwest Virginia Community College
Southwestern Virginia Mental Health Institute
Southwestern Virginia Training Center
State Internal Auditor, Dept. of the
State Police, Dept. of
Supreme Court of Virginia
Taxation, Dept. of
Technology Planning, Dept. of
Technology, Secretary of
Thomas Nelson Community College
Tidewater Community College
Tourism Corporation, Virginia
Transportation, Dept. of
Transportation, Secretary of
Treasury, Dept. of the
University of Virginia
University of Virginia College at Wise
University of Virginia Medical Center
VA School for the Deaf and Blind-Staunton
VA School for Deaf, Blind & Multi-Disabled -
Hampton
Veterans Affairs, Dept. of
Virginia Alcohol Safety Action Program,
Commission on
Virginia Baseball Stadium Authority
Virginia College Savings Plan

Virginia Commonwealth University
Virginia Criminal Sentencing Commission
Virginia Freedom of Information Advisory Council
Virginia Highlands Community College
Virginia Information Providers Network
Virginia Military Institute
Virginia Office for Protection and Advocacy
Virginia Polytechnic Institute and State University
Virginia Resources Authority
Virginia State Bar
Virginia State University
Virginia Treatment Center for Children
Virginia Veterans Care Center
Virginia Western Community College
Virginia Workers Compensation Commission
Western State Hospital
Western Tidewater Community Services Board
Woodrow Wilson Rehabilitation Center
Wytheville Community College
Youth, Commission on

COMMONWEALTH OF VIRGINIA
 DEPARTMENT OF SOCIAL SERVICES

**CHILDREN'S HEALTH INSURANCE
 COMMUNICATION FORM**

COUNTY/CITY:	MMIS ID NUMBER:
CASE NAME:	

Please cancel FAMIS coverage for the following child(ren) who has been found eligible for Medicaid. The FAMIS CPU must receive this form by the 10th of the month, for the FAMIS cancellation to be effective the last day of the current month. If the FAMIS CPU receives the form after the 10th of the month, FAMIS cancellation will be effective the last day of the following month.

NAME	SSN	DATE OF BIRTH	FAMIS RECIPIENT ID

The following change has been reported:

CHECK THE APPROPRIATE CHANGE	GIVE DATE CHANGE OCCURRED AND EXPLANATION
Moved or planning to move – give new address	
Change in income from a job	
Change in income other than from a job	
Change in the number of persons in the house	
Change in insurance status	
Retroactive cancellation required; child in LTC, Residential Facility, or Foster Care	Admission date _____ FAMIS cancel date _____
Other change	

 (WORKER NAME/NUMBER) (DATE) (TELEPHONE NUMBER)

Please send completed form via the courier to the FAMIS Contract Monitor at FAMIS CPU, 700 E. Franklin Street, Suite 220, Richmond, VA 23219, or fax to the FAMIS Contract Monitor at 804-698-5654.

FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1 ST 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens, <i>other than Cuban or Haitian Entrants</i> , paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible
	ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE		
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	Eligible		
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B	Eligible		
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order	Eligible		
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	Eligible		

UNQUALIFIED ALIEN GROUPS <u>NOT</u> ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)
Aliens residing in the U.S. under orders of supervision (I-220B)
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)
Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing (Immigration Judge Court Order)
Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing (INS Contact)
Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired
Visitors (non-immigrants): tourists, diplomats, foreign students, temporary workers, etc. (I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-I186; SW-434; I-95A)

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M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid *and have income in excess of the Medicaid limits*, but whose family income is less than or equal to 150% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

FAMIS *MOMS* is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The DMAS will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Case management and ongoing case maintenance, and selections for managed care, are handled by the FAMIS CPU.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 150% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid *and has income in excess of the Medicaid limits*;
- she is a resident of Virginia;
- she is uninsured;
- she is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 3 to Chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 150% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Policy** The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Applicable Requirements** The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:
- Virginia residency requirements;
 - assignment of rights;
 - *application for other benefits*;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS Nonfinancial Requirements** The *FAMIS* nonfinancial eligibility requirements are:
- 1. Citizenship & Alienage Requirements** FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.
- a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.
 - b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**:
 - refugees (see M0220.310 A. 2),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52)
 - c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:
 - lawful permanent residents (LPRs),

- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

Appendix 4 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

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| 3. No Emergency Services for Unqualified Aliens | Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens. |
| 4. SSN not Required | The applicant is not required to provide an SSN or proof of an application for an SSN. |
| 5. HIPP not Applicable | Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do NOT apply to FAMIS. |

D. FAMIS MOMS Covered Group Requirements

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| 1. Verification of Pregnancy | Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner. Documentation of how the pregnancy was verified must be included in the case record. |
| 2. Must be Uninsured | The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured. |
| 3. IMD Prohibition | The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD). |
| 4. State Employee Health Benefits Prohibition | A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage. |

See Appendix 2 to Chapter M21 for a list of state government agencies.

M2220.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

3. Family Member

ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, “family member” means the pregnant woman’s spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. “Family member” includes the pregnant woman’s stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee’s unmarried **dependent** child or stepchild under age 23 years.

4. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.

Health benefit plan does NOT mean:

- *Medicare, Medicaid or State/Local Hospitalization;*
- accident only;
- credit or disability insurance;

For applicants under the age of 18, the parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage.

Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application.

For applicants age 18 or older, the applicant, family substitute relative, authorized representative or the guardian can sign the application.

**B. Eligibility
Determination**

**1. Pregnant
Teenager Under
Age 19**

When an application is received for a pregnant teenager who is under age 19, is not eligible for Medicaid and has income in excess of the Medicaid limits, process her eligibility in the following order:

- a. first, process eligibility as a Medicaid MI child under age 19; if not eligible because of excess income, go to item b.*
- b. second, process eligibility as a Medicaid MI pregnant woman; if not eligible because of excess income, go to item c.*
- c. third, process eligibility as a FAMIS child under age 19; if not eligible because of excess income, go to item d.*
- d. fourth, process eligibility as a FAMIS MOMS pregnant woman. In order to complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be given the opportunity to have a medically needy evaluation completed.*

2. 10-day Processing

Applications for *pregnant women* must be processed as soon as possible, but no later than 10 working days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

**3. Notice
Requirements**

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, a Notice of Action on Medicaid and FAMIS Programs (NOA), form #032-03-008 (see subchapter M0130, Appendix 1) must be sent to the applicant. The NOA must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the application.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

**C. Case Setup
Procedures for
Approved Cases**

Because Medicaid and FAMIS MOMS are separate programs, Medicaid eligible individuals and FAMIS MOMS eligible individuals cannot share the same base case number in the Virginia Medicaid Management Information System (MMIS). Only individuals eligible for the same program (Medicaid or FAMIS/FAMIS MOMS) can share the same base case number in the MMIS.

When an individual is determined eligible for FAMIS MOMS and the individual has family members enrolled in Medicaid, the FAMIS MOMS individual must be given a new MMIS base case number when enrolled.

After the pregnant woman is enrolled in MMIS, the MMIS case must be transferred to the FAMIS CPU by changing the worker number to "V0000."

The local DSS worker cannot change the FIPS code or make any other change to the case after the case has been transferred to the FAMIS CPU in MMIS.

**D. Entitlement and
Enrollment**

**1. Begin Date of
Coverage**

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.

**2. No Retroactive
Coverage**

There is no retroactive coverage in the FAMIS MOMS program.

3. Aid Category

The FAMIS MOMS aid category (AC) is "005."

**E. Notification
Requirements**

Notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS.

If the pregnant woman is eligible for FAMIS MOMS, the notice must inform the pregnant woman that the case has been transferred to the FAMIS CPU and that further information on the program will come from the FAMIS CPU.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a notice that she is not eligible for

either program and must be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and an Application for Benefits to the pregnant woman and advise her that if the signed application is returned within 10 days the original application date will be honored.

NOTE: The ADAPT NOA meets the notification requirements. When a NOA is generated by ADAPT, do not send the NOA form #032-03-008.

**F. Transfer Case to
FAMIS CPU**

Once the enrolled FAMIS MOMS case is transferred in MMIS and the notice is sent to the family, the case must be transferred to the FAMIS CPU for ongoing case maintenance.

**G. Application Required
for Newborn**

The newborn child born to a FAMIS MOMS enrollee is NOT deemed eligible for FAMIS or Medicaid. The newborn's parent, guardian or authorized representative must file an application for medical assistance for the newborn to have the newborn's eligibility determined for Medicaid and/or FAMIS.

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.